

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 14247
REG. NO.FOR
1- STATE
REGISTRAR

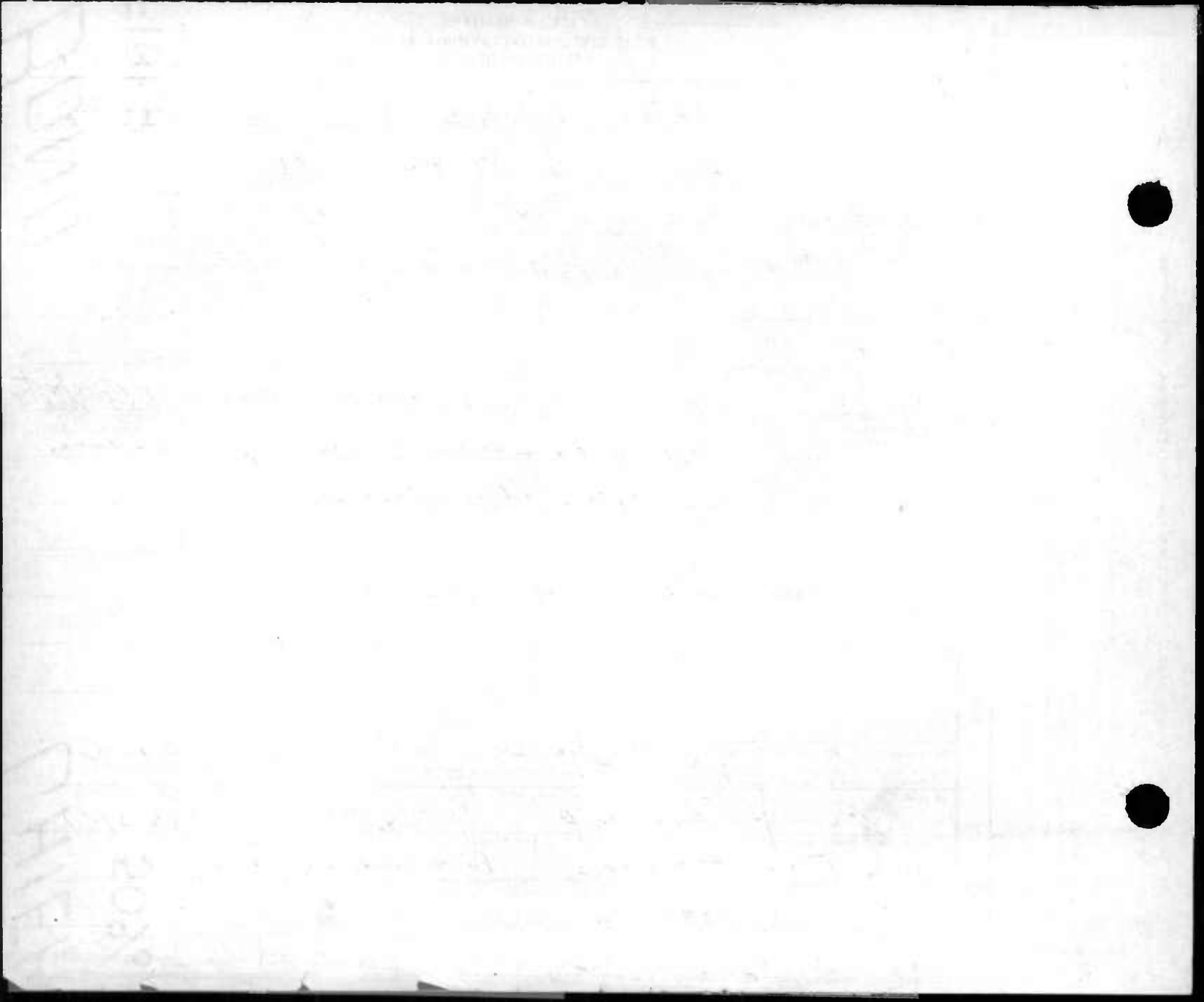
1. DECEASED NAME (TYPE OR PRINT) FIRST MURIEL MIDDLE Wesley LAST ALHWINE			2a. DATE OF DEATH MONTH 5 DAY 3 YEAR 1987		2b. HOUR 8:55 M
3. SEX FEMALE	4. RACE White	5. DATE OF BIRTH MONTH 2 DAY 27 YEAR 1905		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE, Md	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL County MD	
10. CITY OR TOWN OF DEATH MANCHESTER, Md	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LONGVIEW HOME 3332 MAIN ST MANCHESTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE NJ	13b. COUNTY Middlesex	13c. CITY OR TOWN Highland pk	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 11 Raritan Ave. 99999	

14. FATHER'S NAME FIRST ERNEST MIDDLE LAST GARDNER		15. MOTHER'S MAIDEN NAME FIRST Anna MIDDLE LAST Unknown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 158-14-1081	17. INFORMANT ADDRESS Longview Home 3332 Main St. Manchester	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>upper gastrointestinal terminal bleeding</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>peptic ulcer disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours.
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>arteriosclerotic heart disease</u>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) this hospital attended the deceased from <u>Jan 24</u> , 19 <u>87</u> , to <u>May 3</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>May 2</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Dr. Justin M.D.</u>	DEGREE M.D.		22c. DATE SIGNED 5/3/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. V. FAUSTINO, M.D.	22e. ADDRESS 18000 paton Maryland		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5-7-87	23c. NAME OF CEMETERY OR CREMATORY Lake Nelson	23d. LOCATION CITY OR TOWN COUNTY STATE Piscataway Middlesex N. J.
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md.		25a. DATE REC'D. BY REGISTRAR MAY 5 1987	
		25b. REGISTRAR'S SIGNATURE Julia Davidson-Radabaugh	



053711 MAY 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 14248
REG. NO.

FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Eugene Neal Brosenne</i>		2a DATE OF DEATH MONTH DAY YEAR <i>5-8-87</i>		2b HOUR <i>10:45 A.M.</i>	
3 SEX <i>male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>12 22 06</i>		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <i>80</i> YRS	
7a BIRTHPLACE (STATE OR FOREIGN) <i>Md.</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll</i> MD	
10 CITY OR TOWN OF DEATH <i>Sykesville Md.</i>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE STREET ADDRESS) <i>Sykesville Eldredge</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Farmer</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Agriculture</i>	
13a STATE <i>Md.</i>		13b COUNTY <i>Carroll</i>		13c CITY OR TOWN <i>Sykesville</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Harry W. Brosenne</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary E. O'Neill</i>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>no</i>		16b SOCIAL SECURITY NO. <i>217-26-5027</i>	
17 INFORMANT <i>Mary E. O'Neill</i>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastasis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Prostate Carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____		19 ADDRESS <i>8120 Hickendale Rd. Balto. MD 21234</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <i>January 3, 1980</i> to <i>May 8, 1987</i> , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>Jose L. Chapulte</i>		DEGREE <i>M.D.</i>		22c DATE SIGNED		22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jose L. Chapulte, M.D.</i>	
22e ADDRESS <i>6362 Barnett Ave. SYKESVILLE, MD</i>		23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b DATE <i>11 May 87</i>		23c NAME OF CEMETERY OR CREMATORY <i>St. John's Cemetery</i>	
23d LOCATION <i>Elliot City Howard Md.</i>		23e DATE REC'D. BY REGISTRAR <i>MAY 14 1987</i>		23f REGISTRAR'S SIGNATURE <i>[Signature]</i>		23g REGISTRAR'S NAME <i>[Name]</i>	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then the funeral director should return the certificate to the State Dept. of Health and Mental Hygiene promptly by mail or in person.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 14249
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EFFIE M. BROOKS			2a. DATE OF DEATH MONTH DAY YEAR 5 10 87		2b. HOUR 0700 A.M.						
3. SEX F		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 11 1889		6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.					
10. CITY OR TOWN OF DEATH Westminster, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. Gen. Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hwf		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Upperco		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 15911 Trenton Rd. 21155			
14. FATHER'S NAME FIRST MIDDLE LAST John M. Bossom		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie M. Royston		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 213-74-1520		17. INFORMANT ADDRESS Mr. Wilbur D. Brooks, Owings Mills, Md.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

Hypertension

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 5/9 1987 to 5/10 1987, that (I) (we) last saw the deceased alive on 5/9 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
23. SIGNATURE Julia Sanders-Randall JMD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/10/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-13-87		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Upperco Balto Md.	
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md.				25. DATE RECD. BY REGISTRAR MAY 14 1987			
				26. REGISTRAR'S SIGNATURE Julia Sanders-Randall			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be issued within 24 hours after death. Page A may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DEPT. OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C.

1. The Adjutant General is the principal administrative officer of the Army. He is responsible for the management of the personnel, property, and financial affairs of the Army. He is also responsible for the preparation and distribution of orders, regulations, and instructions. He is the principal advisor to the Chief of Staff on all matters relating to the administration of the Army.

2. The Adjutant General is the principal officer of the Adjutant General's Office. He is responsible for the management of the office and for the performance of the duties assigned to him. He is also responsible for the supervision of the personnel and property of the office.

3. The Adjutant General is the principal officer of the Adjutant General's Office. He is responsible for the management of the office and for the performance of the duties assigned to him. He is also responsible for the supervision of the personnel and property of the office.

4. The Adjutant General is the principal officer of the Adjutant General's Office. He is responsible for the management of the office and for the performance of the duties assigned to him. He is also responsible for the supervision of the personnel and property of the office.

5. The Adjutant General is the principal officer of the Adjutant General's Office. He is responsible for the management of the office and for the performance of the duties assigned to him. He is also responsible for the supervision of the personnel and property of the office.

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8. The Adjutant General is the principal officer of the Adjutant General's Office. He is responsible for the management of the office and for the performance of the duties assigned to him. He is also responsible for the supervision of the personnel and property of the office.

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10. The Adjutant General is the principal officer of the Adjutant General's Office. He is responsible for the management of the office and for the performance of the duties assigned to him. He is also responsible for the supervision of the personnel and property of the office.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM T-101. GIVE PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 4250	
1. DECEASED NAME (TYPE OR PRINT) MARGARET MARY BURK						2a. DATE KNOWN OF DEATH ESTIMATED 5/26/87		2b. HOUR 2204			
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH (MONTH DAY YEAR) 10/21/10	6. AGE (IN YEARS) (LAST BIRTHDAY) 76 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD 5/21/87		2d. HOUR 1926			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CANADA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD					
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 76 PENNA AVE				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Treat Shop - Candy Store		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND		13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 76 PENNA AVE			
14. FATHER'S NAME (FIRST MIDDLE LAST) Joseph Gross				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Mary							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO.		17. INFORMANT Terry Burk 841665 Main St. Westminster Md. 21157					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DILATATIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Daniel J. Welliver				TITLE (SPECIFY) Asst. Dir.		MEDICAL EXAMINER 218 WASHINGTON AVE. WESTMINSTER MD.		DATE SIGNED 5/27/87			
EXAMINER'S NAME (TYPE OR PRINT) DANIEL J. WELLIVER				ADDRESS 254 E. Main St. Westminster Md.							
23a. BURIAL, CREMATION, REMOVAL (ECFY) Cremation		23b. DATE 5-28-1987		23c. NAME OF CEMETERY OR CREMATORY Carroll Cremation Service		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Carroll Md.					
24. FUNERAL DIRECTOR NAME Thomas J. Fletcher				ADDRESS 254 E. Main St. Westminster Md.		25a. DATE REC'D. BY REGISTRAR JUN 1 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Rodman			

MEDICAL CERTIFICATION

RECEIVED WHITE OCEANIC CO.
CARRIAGE UNITED STATES
WESTINGHOUSE ELECTRIC & LIGHTING CO.
CHICAGO, ILL.

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054261 MAY 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 4 2 5 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Dorothy M. Campbell			2a. DATE OF DEATH MONTH DAY YEAR May 17, 1987		2b. HOUR 1 p.m.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 14, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD	
10. CITY OR TOWN OF DEATH Sykesville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sykesville Elder Care		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Housewife	
13a. STATE Maryland		13b. COUNTY Carroll	13c. CITY OR TOWN Finksburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE P.O. Box 414 21048
14. FATHER'S NAME FIRST MIDDLE LAST George Murray		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hanna Diehlman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 212-36-1695		17. INFORMANT ADDRESS William M. Campbell P.O. Box 414 Finksburg, Md. 21048	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Accident</u> <u>minutes</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerosis</u> <u>Years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Malnutrition</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <u>July 1986</u> to <u>present</u> , 19 <u>87</u> , that (2) (we) last saw the deceased alive on <u>May 14</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>M. K. McEvoy</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>5/18/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>McEvoy, M. K.</u>		22e. ADDRESS <u>PO Box 1229 Sykesville MD</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>May 20, 1987</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR NAME <u>Leroy M. & Russell C. Witzke</u>		ADDRESS <u>1630 Edmondson</u>		25a. DATE REC'D. BY REGISTRAR <u>MAY 21 1987</u>	
				25b. REGISTRAR'S SIGNATURE <u>Julia [Signature]</u>	

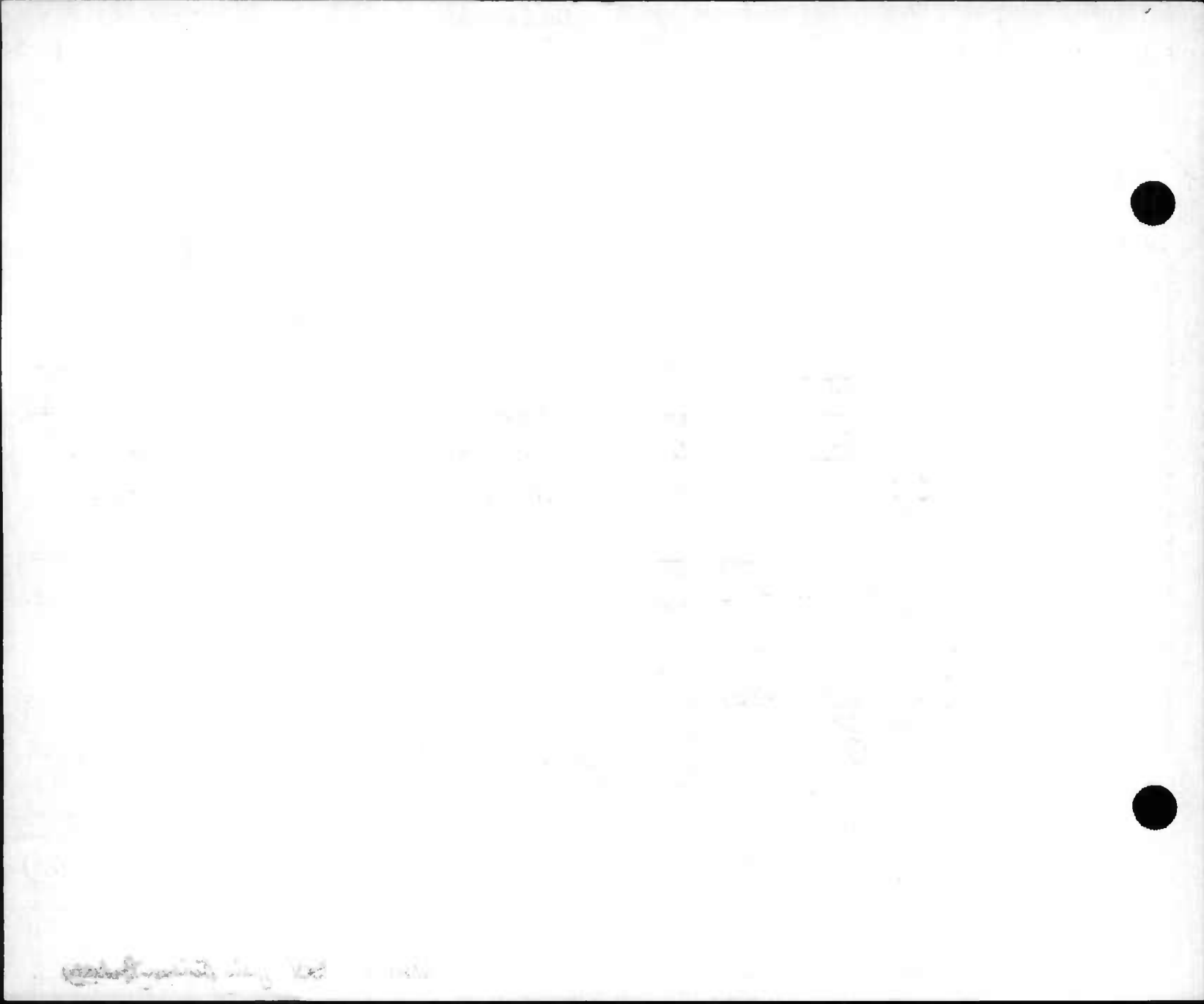
MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 7 1 4 2 5 2 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret Jean Casper				2a. DATE OF DEATH MONTH DAY YEAR May 22, 1987				2b. HOUR 11 30 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 17, 1947		6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 2 YRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH B Carroll County MD.				
10. CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County Gen. Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.		13b. COUNTY Carroll	13c. CITY OR TOWN Finksburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2826 Benson Road 21048		
14. FATHER'S NAME FIRST MIDDLE LAST Vernon William Snyder			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bernice A. McCauley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-50-1966		17. INFORMANT John E. Casper ADDRESS 2826 Benson Rd. Finksburg, Md. 21048				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Breast Cancer DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: c								
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 5/19 1987 to 5/22 1987 , that (I) (we) lost saw the deceased alive on 5/19 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Davis M. Hahn				DEGREE MD		22c. DATE SIGNED 5/24/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Davis M. Hahn				22e. ADDRESS 5301 Loch Raven Blvd 21239				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 26, 1987		23c. NAME OF CEMETERY OR CREMATORY Evergreen Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg, Carroll, Md.		
24. FUNERAL DIRECTOR NAME H. E. Schmitt				ADDRESS Owings Mills, Md.		25a. DATE REC'D. BY REGISTRAR MAY 25 1987		
				25b. REGISTRAR'S SIGNATURE John Benson-Randall				

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STATE OF NEW YORK
IN SENATE
January 10, 1910

REPORT OF THE
COMMISSIONER OF THE LAND OFFICE

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 14253
REG. NO.

4. DECEASED NAME (TYPE OR PRINT) James L. Cross			20. DATE OF DEATH MONTH DAY YEAR 5 30 87		2b. HOUR 6:45 AM
3 SEX male	4 RACE white	5. DATE OF BIRTH MONTH DAY YEAR 4 12 1921		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD	
10. CITY OR TOWN OF DEATH Sykesville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse/manager		12b. KIND OF BUSINESS OR INDUSTRY Agriculture
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Carroll	13c. CITY OR TOWN Sykesville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Cross		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Kiepper		13e. STREET ADDRESS / ZIP CODE 4-1 Bethway Dr. 21784	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 411 10 3681		17. INFORMANT Mr. Charles Cross	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several YRS.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): SEIZURE DISORDER					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8:20 19 86 to 3:18 19 87, that (I) (we) last saw the deceased alive on 3:18 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE M. Pajpara MD		DEGREE		22c. DATE SIGNED 6-30-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. PAJPARA MD		22e. ADDRESS 224 Washington Hts. Westminster			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 06-02-87		23c. NAME OF CEMETERY OR CREMATORY Crestlawn Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Mamotsville Howard MD		23e. DATE REC'D. BY REGISTRAR 6/1/87			
24. FUNERAL DIRECTOR NAME Haight Funeral Home		ADDRESS Sykesville, MD		25a. REGISTRAR'S SIGNATURE Jalic Davidson-Rondau	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

052362

RECEIVED
JAN 10 1964

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "RECEIVED" and "JAN 10 1964" are visible.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 14254

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Irene P. Doebler</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>5-23-87</i>		2b. HOUR <i>9 PM</i>
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>3 1 02</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>85</i> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll County</i> MD.	
10. CITY OR TOWN OF DEATH <i>Westminster</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>WNCe</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>home</i>
13a. STATE <i>MD.</i>		13b. COUNTY <i>Carroll</i>	13c. CITY OR TOWN <i>Westminster</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>1214 Maple Crest Drive 21157</i>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Alexander Bennett</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Magdalene Perry</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>148-10-8310D</i>		17. INFORMANT ADDRESS <i>Inez Kievning, 13e</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Alzheimer's Disease</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>years</i>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <i>Acute urinary tract infection since 5/14/87</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <i>6/1/83</i> , 19____, to <i>Now</i> , 19____, that (I) (we) last saw the deceased alive on <i>4/29/87</i> , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
27b. SIGNATURE <i>J. H. Capice</i>		DEGREE <i>MD</i>		27c. DATE SIGNED <i>5/23/87</i>	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. H. CAPICE MD.</i>		27e. ADDRESS <i>104 N Main, Union Bridge MD 21790</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>5/26/87</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Restland Memorial</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Union Bridge MD 21790</i>
24. FUNERAL DIRECTOR NAME <i>Robert K. Pritts, Sr., Westminster, MD</i>		25a. DATE REC'D. BY REGISTRAR <i>JUN 01 1987</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

055529

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been issued by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

025259



NOTICE
OF
S. H. H.

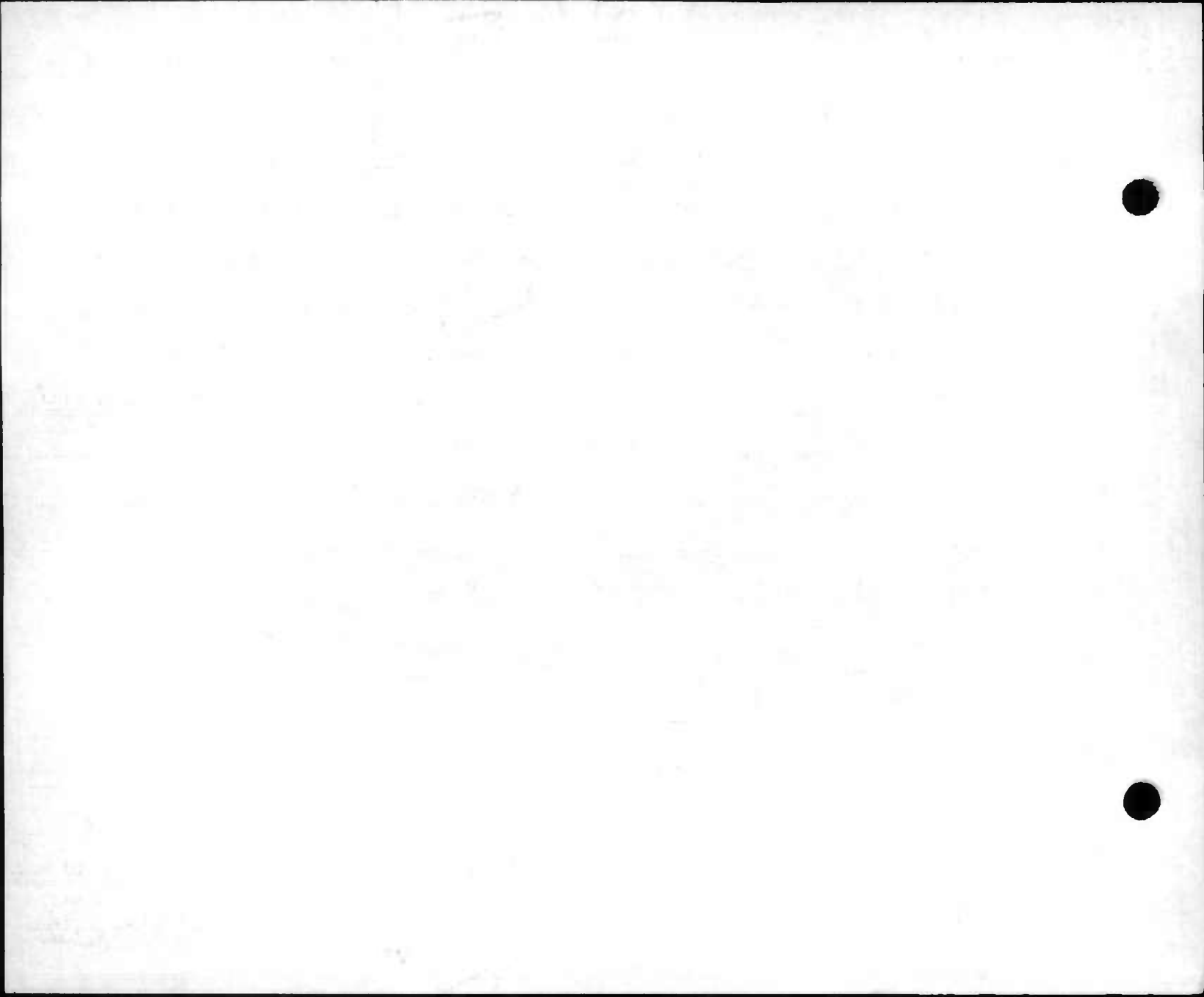
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8714255
REG. NO.FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE E LAST DUBS			2a. DATE OF DEATH MONTH DAY YEAR 5 . 6 . 87			2b. HOUR 5:10 A.M.			
3. SEX F		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 1 . 16 . 1902		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL COUNTY MD.			
10. CITY OR TOWN OF DEATH LINE BORO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5237 S MILL STREET				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND			13b. COUNTY CARROLL		13c. CITY OR TOWN LINEBORO		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Monroe			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Albright			13e. STREET ADDRESS 5237 S MILL STREET			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 16-20-4012		17. INFORMANT ADDRESS Paul Baughman 5237 S. Mill St Lineboro Md				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Accident DUE TO, OR AS A CONSEQUENCE OF b) HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: b PERIPHERAL VASCULAR DISEASE									
19a. DATE OF OPERATION -			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1-30-80, 19, to 3-31-87, 19, that (I) (we) lost saw the deceased alive on 3-31-87, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
27b. SIGNATURE Mojars			DEGREE			27c. DATE SIGNED 5.6.87			
27d. PHYSICIAN'S NAME (TYPE OR PRINT) S. D. MORSARIA, M.D.			27e. ADDRESS 3000 MANCHESTER ROAD, MANCHESTER MD 21102						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 6, 1987		23c. NAME OF CEMETERY OR CREMATORY St. Jacobs Stone Church		23d. LOCATION CITY OR TOWN COUNTY STATE Brookbeck York PA		
24. FUNERAL DIRECTOR ADDRESS 53 MAIN ST Glen Ridge NJ			25a. DATE REC'D. BY REGISTRAR MAY 13 1987			25b. REGISTRAR'S SIGNATURE Julia Bender			

MEDICAL CERTIFICATION



052602 MAY

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14256

1. DECEASED NAME (TYPE OR PRINT) ANNA H ELDER				2a. DATE KNOWN OF DEATH MONTH DAY YEAR 5-2 1987				2b. HOUR OF DEATH 1987 1600			
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 8 3 1888	6. AGE (IN YEARS) (LAST BIRTHDAY) 98 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 2 1987	7d. HOUR 1820	9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL COUNTY MD.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Artist		12b. KIND OF BUSINESS OR INDUSTRY Self-Employed			
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2840 OLD TANEYTOWN AVE				12c. STREET ADDRESS 2840 Old Taneytown Rd			12d. CITY OR TOWN Westminster, MD.		
13a. STATE MARYLAND		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2840 Old Taneytown Road 21157			
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 234-62-0557				17. INFORMANT Mrs. Jean Creamer				ADDRESS 2840 Old Taneytown Rd. Westminster, MD. 21157			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ARTERIO-SCLEROTIC CARDIOVASCULAR DS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS 10 YEARS											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Daniel J. Welliver				TITLE (SPECIFY) DEPUTY				DATE SIGNED 52 87			
EXAMINER'S NAME (TYPE OR PRINT) DANIEL I. WELLIVER M.D.				ADDRESS 212 WASHINGTON HEIGHTS, WESTMINSTER, MD.				23a. DATE REC'D. BY REGISTRAR MAY 4 1987			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5/4/87		23c. NAME OF CEMETERY OR CREMATORY Westview Memorial Park				23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Baltimore, MD.			
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc. ADDRESS 8728 Liberty Road Randallstown, MD. 21133						25a. DATE REC'D. BY REGISTRAR MAY 4 1987					
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE. DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

ONE

MINUTE

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 14257
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SADIE E FOLK			2a. DATE OF DEATH MONTH DAY YEAR 05 30 1987		2b. HOUR 9:30 P		
3. SEX FEMALE		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 11 03 1890		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD	
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Lutheran Village		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE PA		13b. COUNTY YORK		13c. CITY OR TOWN Hanover		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Martin S. Painter		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susanna Lucabaugh		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 218-34-1728	
17. INFORMANT Cathy L Jennings		18. ADDRESS 1210N CLV		19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) YEARS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH WEEKS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 9/10 19 81 to 5/30 19 87 , that (1) we last saw the deceased alive on 5/30 19 87 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (2) we did view the body after death.							
22b. SIGNATURE Wm R Linticum, MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/30/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm. R. LINTICUM, MD		22e. ADDRESS TANEX TOWN, MARYLAND 21787					
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE June 2, 1987		23c. NAME OF CEMETERY OR CREMATORY LAZARUS Cem.		23d. LOCATION CITY OR TOWN COUNTY Lineboro, Carroll, Md.	
24. FUNERAL DIRECTOR R. Gary Dighten		ADDRESS Manchester, Md		25a. DATE REC'D. BY REGISTRAR JUN 1 1987		25b. REGISTRAR'S SIGNATURE Julia Sanders-Rodgers	

EDMUND

1800

1800

055012 JUN

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE TIME, DAY, MONTH, YEAR, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THIS PAGE. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

FOR STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 4258	
1. DECEASED NAME (TYPE OR PRINT) Gertrude Green										2a. DATE KNOWN OF DEATH 5 30 19 87										2b. HOUR 10	
3. SEX F		4. RACE BLACK		5. DATE OF BIRTH 12/27/33		6. AGE (IN YEARS) 54 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 5 30 19 87		2d. HOUR 10							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TARBORO, N. CAR.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY				MD					
10. CITY OR TOWN OF DEATH BALTO.				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL CO. HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE MD.				13b. COUNTY SYKESVILLE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 5300 HODGE RD. 21784											
14. FATHER'S NAME (FIRST MIDDLE LAST) JAMES BERTRAND				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) MARTHA BERTRAND				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO													
17a. SOCIAL SECURITY NO. 241-62-6621				17. INFORMANT CHARLES GREEN								ADDRESS 5300 HODGES RD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic Cardiovascular Disease																					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Known Hypertensive (c) Previous Myocardial Infarction																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL ILLNESS OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE Richard D. Dyer				TITLE (SPECIFY) Deputy				M.D. MEDICAL EXAMINER				DATE SIGNED 30 May 87									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 6/6/87		23c. NAME OF CEMETERY OR CREMATORY DANCY				23d. LOCATION CITY OR TOWN COUNTY STATE TARBORO, NORTH CAROLINA											
24. FUNERAL DIRECTOR NAME Leroy S. Dyer				ADDRESS 4600 Liberty Highway				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE John Anderson									

10

CHANDLER

CHANDLER

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

87 14259

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SLOAN GRISWOLD			2a. DATE OF DEATH MONTH DAY YEAR 5-8-87		2b. HOUR 5 A.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 8-16-26		
6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA - MD.		7b. CITIZEN OF WHAT COUNTRY? USA		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.				
10. CITY OR TOWN OF DEATH SYKESVILLE MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SYKESVILLE ELDERCARE CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STOCK BROKER		
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE 11134 REISTERSTOWN RD. 21117				
13b. COUNTY MD		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. ATER'S NAME FIRST MIDDLE LAST ROBERTSON GRISWOLD		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Abbey Roberts				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 217-22-9811		17. INFORMANT ADDRESS 7309 Second Ave. 21784		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes DUE TO, OR AS A CONSEQUENCE OF (b) Alcoholic Cardiomyopathy years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) Alcoholism years						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Schizophrenia						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (1) (this hospital) attended the deceased from July 1986 to present 19 87 that (1) (we) last saw the deceased alive on May 7 1987 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.				
22b. SIGNATURE M K McEvoy		DEGREE MD		22c. DATE SIGNED 5/8/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M K McEvoy		22e. ADDRESS PO Box 1225 Sykesville MD 21784				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5/9/87		23c. NAME OF CEMETERY OR CREMATORY Carroll Cremation		
23d. LOCATION CITY OR TOWN COUNTY STATE Hampstead, Md.		24. FUNERAL DIRECTOR NAME ADDRESS Eline Funeral Home Reisterstown, Md. 21136		25. DATE REC'D BY REGISTRAR MAY 11 1987		
25. REGISTRAR'S SIGNATURE Julia Dearden-Randall						

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

1901 2112

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs or sections, but the specific words and sentences are difficult to discern.]

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REC. NO. **4260**

FOR
STATE
REGISTRAR

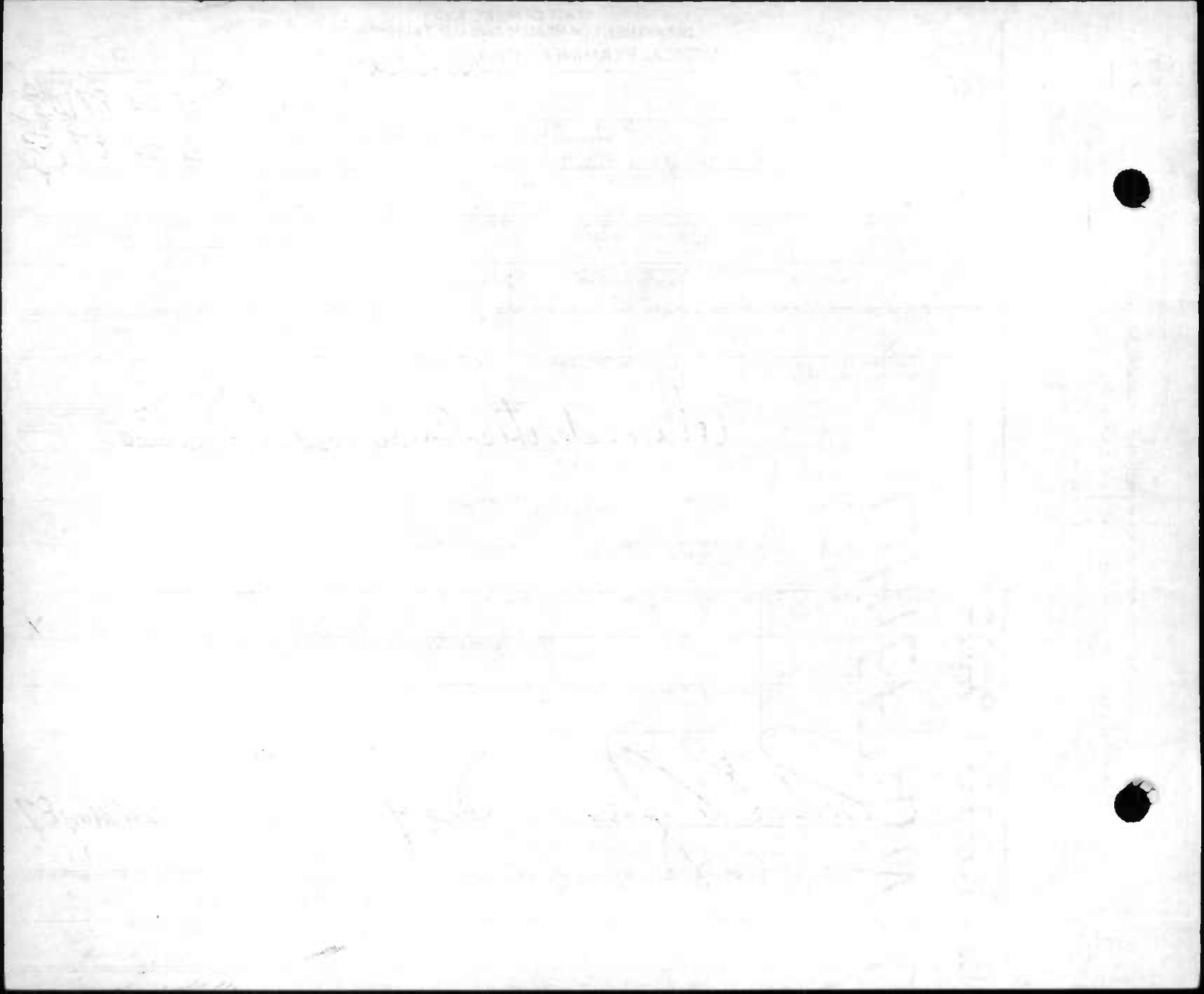
1. DECEASED NAME (TYPE OR PRINT) EMILY ELLEN HARTSOCK			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5 24 1987		2b. HOUR 12:45 M A
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR MARCH 16 1905	6. AGE (IN YEARS) LAST BIRTHDAY 82 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 24 1987
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH NEW WINDSOR		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1011 CHAPEL ROAD		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL CO. MD.	
13a. STATE MARYLAND		13b. COUNTY CARROLL	13c. CITY OR TOWN NEW WINDSOR	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 1011 CHAPEL ROAD
14. FATHER'S NAME FIRST MIDDLE LAST HOWARD HAYS HENDRICKSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NANCY WENTLING		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-05-5776 D		17. INFORMANT ADDRESS MERRY HENDRICKSON-JANE FRAZIER VILLAGE CUMBERLAND MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic atherosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above and an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Richard Jones</i>		TITLE SPECIFY M.D. <i>Deputy</i>		DATE SIGNED 24 May 87	
EXAMINER'S NAME (TYPE OR PRINT) DR. RICHARD JONES		ADDRESS CARROLL CO GENERAL HOSP. WESTMINSTER, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE MAY 28 1987	23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK		23d. LOCATION CITY OR TOWN COUNTY STATE CUMBERLAND ALLEGANY MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS SILCOX-MERRITT FUNERAL HOME CUMBERLAND MARYLAND		25a. DATE REC'D. BY REGISTRAR JUN 1 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2 AND 3 TO THE GENERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
15M 7/77



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be immediately filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 14261

FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Ralph E.D. Hull		2a. DATE OF DEATH MONTH DAY YEAR 05-17-87		2b. HOUR 6: p	
3 SEX male		4 RACE cauc		5. DATE OF BIRTH MONTH DAY YEAR 11-12-00		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.			
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL CO. GENERAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AUTO DEALER		12b. KIND OF BUSINESS OR INDUSTRY AUTO			
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 94 W. Green Street 21157	
14. FATHER'S NAME FIRST MIDDLE LAST HARRY C. HULL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE MYERS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO NONE		16b. SOCIAL SECURITY NO. 213-01-9179		17. INFORMANT ADDRESS ELEANOR NESS 13e 21157	
MEDICAL CERTIFICATION		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio-pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>carcinoma prostate</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>arteriosclerotic cardiovascular disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the deceased) attended the deceased from <u>June</u> , 19 <u>82</u> , to <u>present</u> , 19 <u>86</u> , and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (view) view the body after death.		22b. SIGNATURE <i>Richard Y. Dalrymple</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-18-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Y. Dalrymple, M.D.		22e. ADDRESS Carroll Plaza, Westminster, Md. 21157							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5-20-87		23c. NAME OF CEMETERY OR CREMATORY PIPE CREEK		23d. LOCATION CITY OR TOWN COUNTY STATE MEW WINDSOR CARROLL MD			
24. FUNERAL DIRECTOR NAME <i>Robert K. Luthers</i>		25a. DATE REC'D. BY REGISTRAR MAY 22 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. These pages remain the property of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. (IMPORTANT: If item 21 is marked or item 18 shows any injury, greater traumatic event, the medical examiner must be notified at once.)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 14262

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDITH Grove HUMBERT		MAY 24 87		1205P.M.	
3. SEX FEMALE	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 05 10 15		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.	
10. CITY OR TOWN OF DEATH WESTMINSTER	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL COUNTY GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY home
13a. STATE MD	13b. COUNTY Carroll	13c. CITY OR TOWN Westminster	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 31 Chase St. 21157	
14. FATHER'S NAME FIRST MIDDLE LAST William Grove		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Angevine			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. na	17. INFORMANT ADDRESS Richard Humbert, 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from FEBRUARY 19 87, to MAY 24 19 87, that (I) (we) last saw the deceased alive on MAY 24 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Arthur L. Rudo		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Arthur L. RUDO, MD		22e. ADDRESS 524-B BALTIMORE BLVD WESTMINSTER, MD 21157			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/27/87	23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg Carroll MD	
24. FUNERAL DIRECTOR NAME PRIMO FUNERAL HOME		412 Washington Road Westminster, Md.		25a. DATE REC'D. BY REGISTRAR JUN 01 1987	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the Registrar. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

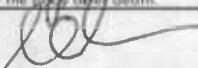
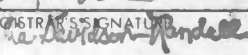
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

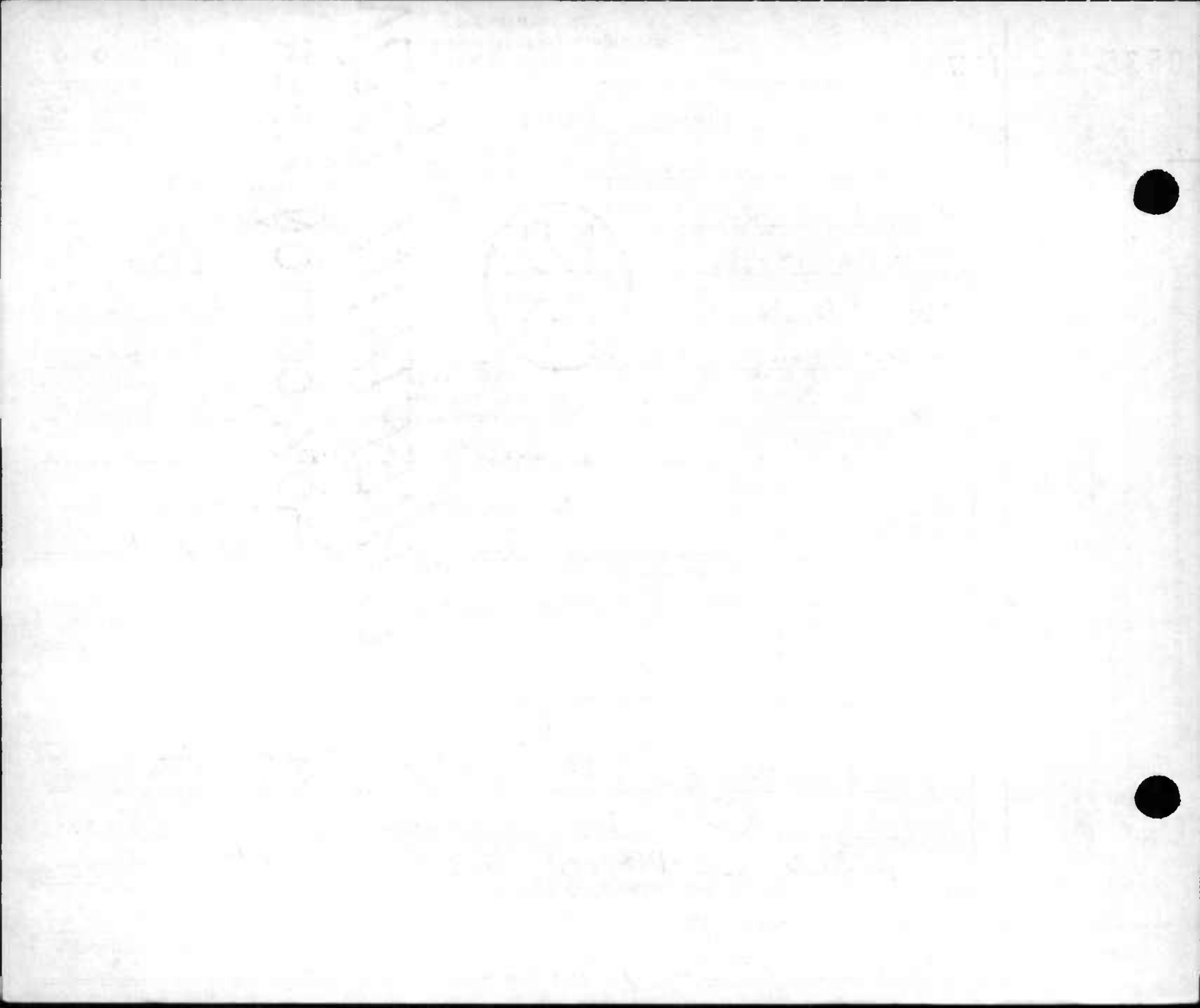
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mabel DIANA Kelly			2a. DATE OF DEATH MONTH DAY YEAR 5-9-87		2b. HOUR 9:50
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 3 20 93		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.	
11. CITY OR TOWN OF DEATH Spikesville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Spikesville Elder Care Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) teacher	12b. KIND OF BUSINESS OR INDUSTRY Baltimore City	
13a. STATE md		13b. COUNTY Baltimore	13c. CITY OR TOWN Ridgely	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 134 Chestnut Hill LA. West 21136
14. FATHER'S NAME FIRST MIDDLE LAST Albert Henry Stiffles		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth A. Cooper			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-20-7707		17. INFORMANT Patricia Ryan ADDRESS 134 Chestnut Hill LA. W. Ridgely, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aspiration Pneumonia</u> DUE TO, OR AS A CONSEQUENCE (c) <u>Cerebrovascular Accident</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>April 1986</u> to <u>May 9, 1987</u> , that (I) (we) last saw the deceased alive on <u>May 5, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) witness the last of death.					
22b. SIGNATURE 		DEGREE		22c. DATE SIGNED 5/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RUBEN REID, M.D.		22e. ADDRESS 914 N. Charles Street Baltimore, Md 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May 12, 1987	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md	
24. FUNERAL DIRECTOR NAME N.S. Echhardt		ADDRESS Cawings Mills, Md.		25a. DATE REC'D. BY REGISTRAR MAY 14 1987	25b. REGISTRAR'S SIGNATURE 

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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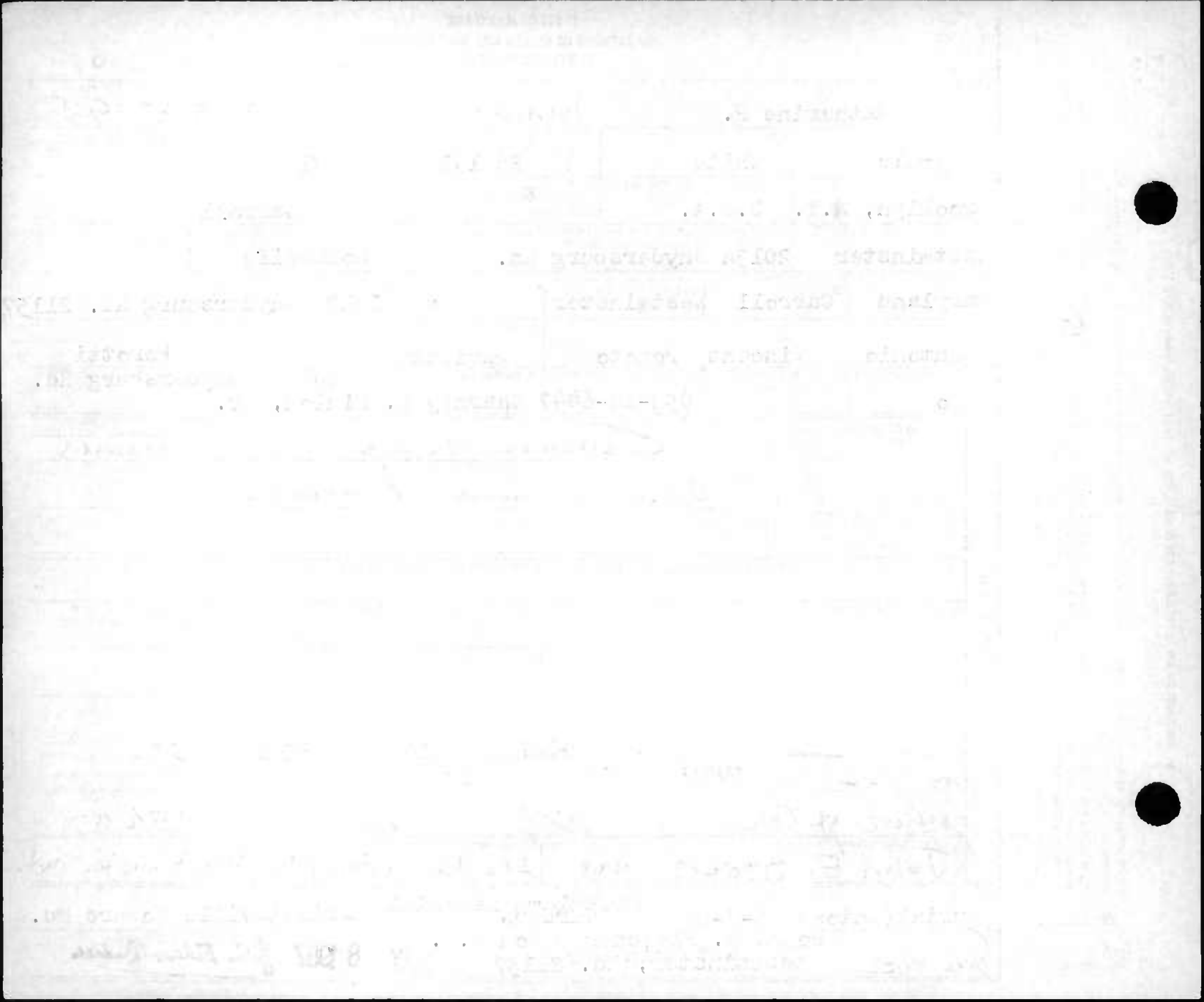
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8714264

REG. NO.

FOR 1. STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Catherine P. Kinion		7a. DATE OF DEATH MONTH DAY YEAR 5 5 87		7b. HOUR 9 ¹⁵ M	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 26 1916		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Brooklyn, N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.			
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2013A Snydersburg Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2013A Snydersburg Rd. 21157	
14. FATHER'S NAME FIRST MIDDLE LAST Antonio Vincent Pomoto		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marietta Perotti		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 053-12-6447		17 INFORMANT 2013A Snydersburg Rd. Charney L. Kinion, Sr.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adenocarcinoma Pancreas</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>Fall</u> , 19 <u>86</u> , to <u>5/5</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>April</u> , 19 <u>87</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> (did not) view the body after death.									
22b. SIGNATURE <u>John E. Steers</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/6/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John E. Steers MD		22e. ADDRESS 222 Washington Hts., Westminster MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial (Entomb)		23b. DATE 5-9-87		23c. NAME OF CEMETERY OR CREMATORY Crestlawn Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Marriottsville Howard Md.			
24. FUNERAL DIRECTOR NAME <u>John Fletcher</u>		24a. NAME Thomas D. Fletcher & Son F.H.		24b. ADDRESS 254 East Main Street Westminster, Md. 21157		24c. DATE REC'D BY REGISTRAR MAY 8 1987		24d. REGISTRAR'S SIGNATURE <u>Julia Bender-Randall</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the following pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.

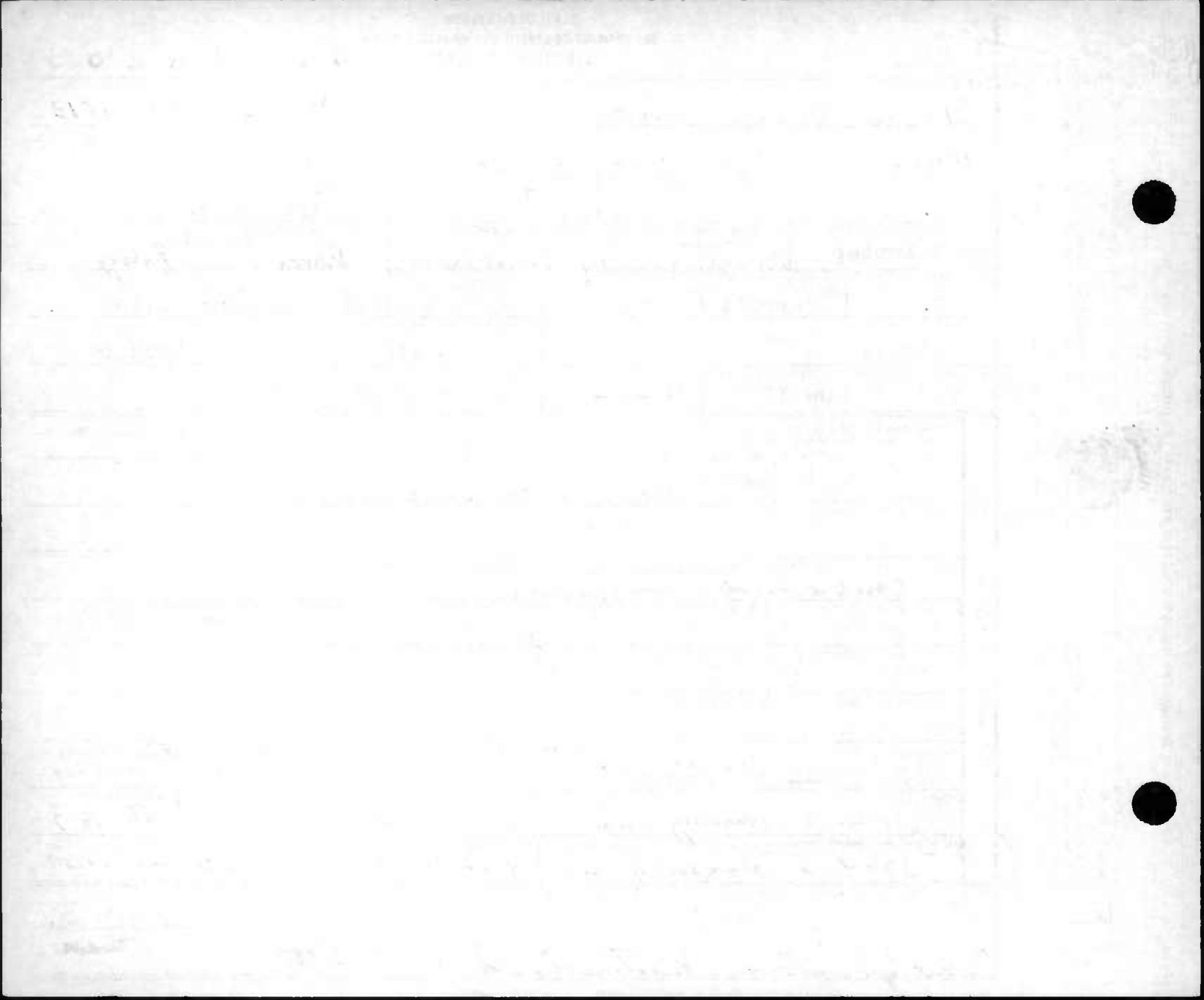
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 14265

1. DECEASED NAME (TYPE OR PRINT) Claude Oliver Leppo				2a. DATE OF DEATH MONTH DAY YEAR May 16, 1987		2b. HOUR 1513 M	
3. SEX male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 8 30 14		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD	
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dancer		12b. KIND OF BUSINESS OR INDUSTRY Bakery	
13a. STATE MD.		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Claude Leppo		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estella Lockard		13e. STREET ADDRESS / ZIP CODE 1416 Pleasant Valley Rd. 21157			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT Doris Leppo		ADDRESS 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cerebrovascular insufficiency</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>May 16</u> , 19 <u>87</u> , to <u>May 16</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>May 16</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>John S. Harshey, MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5/16/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN S. HARSHEY, MD				22e. ADDRESS of anchor st - Westminster, Md. 21157			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/19/87		23c. NAME OF CEMETERY OR CREMATORY Pleasant Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll MD.	
24. FUNERAL DIRECTOR NAME ADDRESS <u>Robert E. Pritch Sr. Westminster Md.</u>				25a. DATE REC'D. BY REGISTRAR MAY 22 1987		25b. REGISTRAR'S SIGNATURE <u>Randall</u>	

BP _____



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
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DHMH - 17
(VR A15 ME (5))FOR Item #16b G628
1- STATE REGISTRAR 6-9-87 cwSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 4 2 6 6

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		7b. HOUR					
DONALD		A.		LIEZERT				5-22-87		19		8		07AM							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		7d. HOUR	
M		W		8/31/1938		48 YRS.						5-22-87		19		8		07AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Ohio		USA										Carroll County									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
Westminster		Carroll County General Hospital		Plant Mgr.- Princess Motor Coach Company																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
MD		Carroll		Westminster		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		51 Ridge Road, 21157													
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Cecil		Elsie		Unknown		270 32 4876		Wood Funeral Home, Kent, Ohio													

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 14267

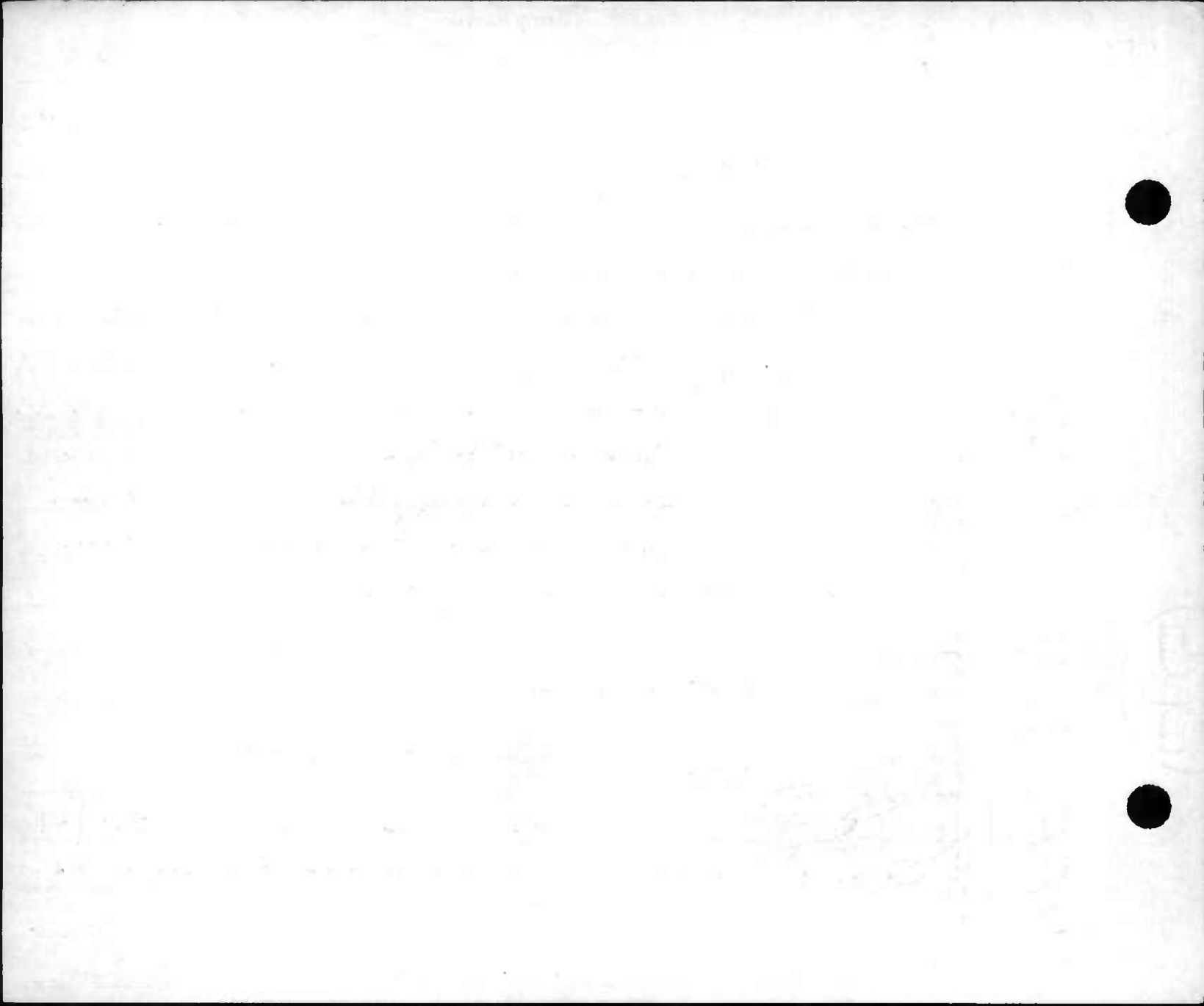
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR			
Evelyn		Mae		Martin				5				9		87		9 P M					
3 SEX		4 RACE		5. DATE OF BIRTH		MONTH		DAY		YEAR		6 AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		7		21		17		69 YRS											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH													
Maryland		USA						Carroll Co. MD.													
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
Hampstead		407 Houcksville Road		Retired		B&D															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
Maryland		Carroll		Hampstead		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		407 Houcksville Road 21074													
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME																			
George W.		Rupp		Bertha M.		Gettier															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS															
no		216-03-9788		Mrs. Georgia Rhoten, Manchester, Md.																	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u>																		1 year			
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischemic Cardiomyopathy</u>																		2 years			
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic Heart Disease</u>																		years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chronic obstructive Pulmonary Disease</u>																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
				9:00 P.M. 5 9 1987																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN									
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>86</u> , to <u>present</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>5/17/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE				DEGREE				ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED									
<u>[Signature]</u>				MD								5/11/87									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS																	
Steven N Shaffer				2111 Hanover Pike Hampstead Md.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN									
Burial				5-12-87				Manchester Cemetery				Manchester Carroll Md.									
24 FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
Eline Funeral Home, Hampstead, Md.								MAY 14 1987				Julia Davidson-Rudolph									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 / 1 4 2 6 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JEAN EMMA MC CANDLESS		2a. DATE OF DEATH MONTH DAY YEAR May 5, 1987		2b. HOUR 8:10 P.M.	
3. SEX Female	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR April 12, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 78 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.	
10. CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 36 Westmoreland Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING (IFE)) Ans. serv.		12b. KIND OF BUSINESS OR INDUSTRY Ans. serv.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY Carroll	13c. CITY OR TOWN Westminster	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Roy Reese		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Bruce			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. na		17. INFORMANT ADDRESS S. Brenneman 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CA OF PANCREAS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 1117, 1987, to 515, 1987, that (I/we) last saw the deceased alive on 415, 1987, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)					
22b. SIGNATURE Howard G. Lannan, MD		DEGREE MD		22c. DATE SIGNED 5/5/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HOWARD G. LANNAN, MD		22e. ADDRESS 215 WASHINGTON HETS, WESTMINSTER			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/8/87	23c. NAME OF CEMETERY OR CREMATORY Meadow Branch		23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll MD
24. FUNERAL DIRECTOR NAME Robert K. Pritts, Sr., Westminster, MD		25a. DATE REC'D. BY REGISTRAR MAY 11 1987		25b. REGISTRAR'S SIGNATURE Julia Dwyer-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of force.

MEDICAL CERTIFICATION



1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 14269

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN MERRYMAN McCORMICK			2a. DATE OF DEATH MONTH DAY YEAR 5-3-87		2b. HOUR 0130M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 5 9 1911		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD	
10. CITY OR TOWN OF DEATH WESTMINSTER	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 69 SMITH AVE.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) news publishing		12b. KIND OF BUSINESS OR INDUSTRY newspaper
13a. STATE MARYLAND		13b. COUNTY CARROLL	13c. CITY OR TOWN WESTMINSTER	13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 69 SMITH AVE 21157
14. FATHER'S NAME FIRST MIDDLE LAST John Edwin McCormick		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katie Norris Merryman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no na		16b. SOCIAL SECURITY NO. 215-01-3278		17. INFORMANT ADDRESS Myrtle R. McCormick, 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF URINARY BLADDER DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ WITH METASTASES					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from MAY 3 1987 to MAY 3 1987 , that (we) last saw the deceased alive on MAY 3 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Daniel I Welliver M.D.		DEGREE M.D.		22c. DATE SIGNED 5-3-87	
22d. PRINT NAME (TYPE OR PRINT) DANIEL I WELLIVER M.D.		22e. ADDRESS 218 WASHINGTON HEIGHTS WESTMINSTER MARYLAND 21157			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/6/87	23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Robert K. Pritts, Sr., Westminster, Md		25a. DATE REC'D. BY REGISTRAR MAY 06 1987			
		25b. REGISTRAR'S SIGNATURE <i>John R. Anderson</i>			

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Main body of handwritten text, organized in columns. The text is very faint and mostly illegible, but seems to be a detailed record or list. There are some words that might be recognizable, such as "LIFE" and "DEATH", but the overall context is unclear.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

14270

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HENRY LOUIS MINGEE			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 5-4-87			2b. HOUR M 7:40P				
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 22, 1937	6. AGE (IN YEARS) LAST BIRTHDAY 49 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5-4-87				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.				
10. CITY OR TOWN OF DEATH Finksburg		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bollinger Mill Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinest		12b. KIND OF BUSINESS OR INDUSTRY Metal			
13a. STATE Md.		13b. COUNTY CARROLL		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 11-2 Gaither Manor Dr. 21784		
14. FATHER'S NAME FIRST MIDDLE LAST Nathaniel Thomas Mingee				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Whaley						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. Korean		17. INFORMANT Ruth Mingee		ADDRESS Sykesville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE Margarita A. Korell			TITLE (SPECIFY) Assistant			DATE SIGNED 5-5-87				
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.			ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial			23b. DATE 5-7-87		23c. NAME OF CEMETERY OR CREMATORY Lake View Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Md.			
24. FUNERAL DIRECTOR NAME Harry W. Haight			ADDRESS Sykesville, Md.			25a. DATE REC'D BY REGISTRAR MAY 7 1987		25b. REGISTRAR'S SIGNATURE Julia Sanders		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXPLAIN IN PENCIL IN ITEM 18. GIVE PAGES 2, 3, AND 4 TO THE FUNERAL DIRECTOR. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM NO. 1, RETURN PAGE 5 FOR YOUR FILES TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS OF DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

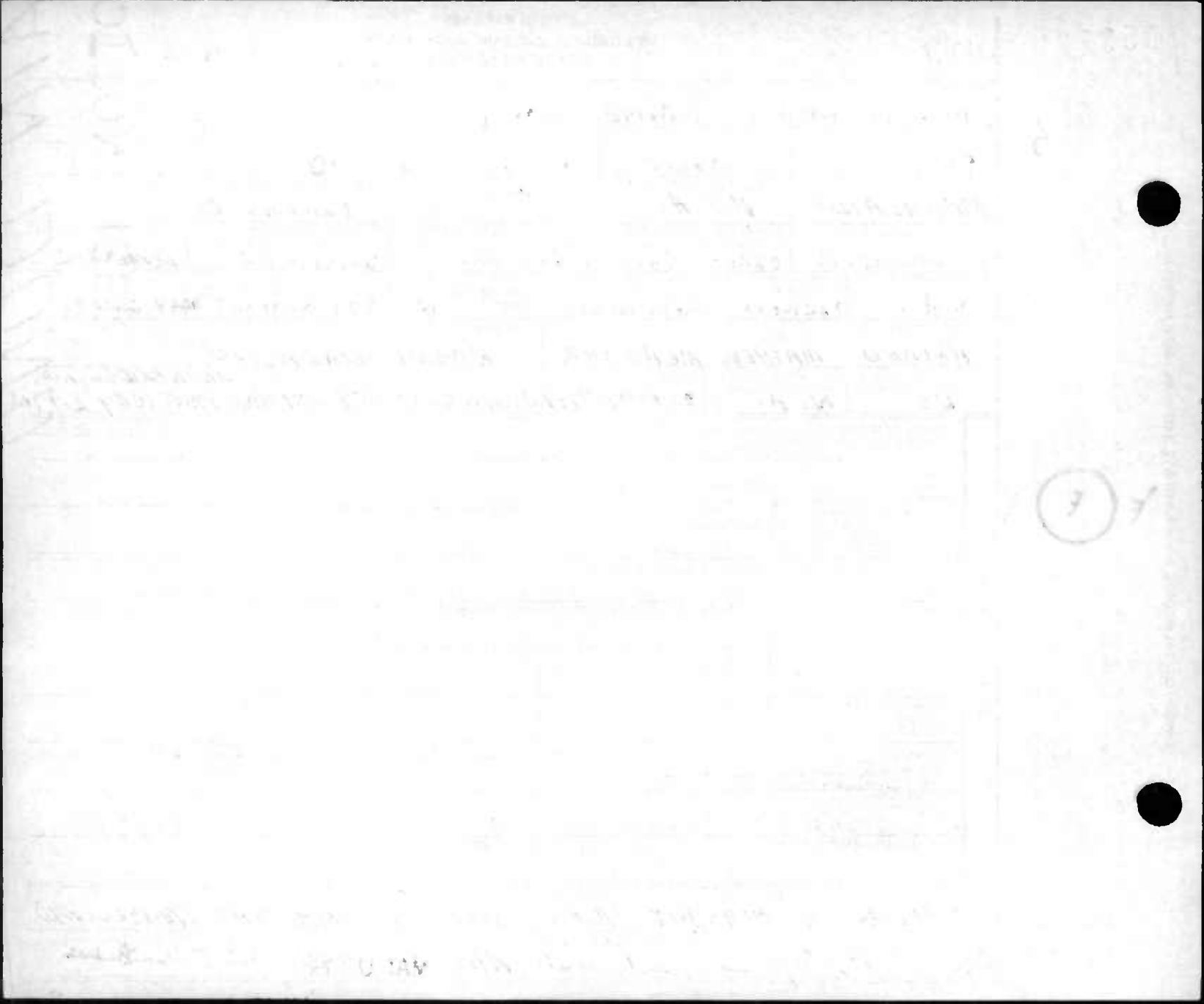
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal, or other disposition of the body. IMPORTANT: If item 21 is marked on item 20, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) NAOMI MAXINE MOXEY				2a. DATE OF DEATH MONTH 5 DAY 5 YEAR 87				2b. HOUR 0740 M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 12 DAY 02 YEAR 46		6. AGE (IN YEARS (LAST BIRTHDAY)) 40 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL CO MD			
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL COUNTY GENERAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
13a. STATE MD		13b. COUNTY CARROLL		13c. CITY OR TOWN UNION BRIDGE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 831 RAMPART WAY 21791	
14. FATHER'S NAME FIRST ROLAND MIDDLE MATHEW LAST MCALLISTER		15. MOTHER'S MAIDEN NAME FIRST NAOMI MIDDLE UNKNOWN LAST UNKNOWN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) N.A.		16b. SOCIAL SECURITY NO. 214-46-7959		17. INFORMANT ADDRESS UNION BRIDGE, MD, JOSEPH C. MOXEY 831 RAMPART WAY 21791	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ORGANIC BRAIN SYNDROME DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DIBETES MELLITUS DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH WEEKS YEARS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: DIABETIC NEUROPATHY DIABETIC NEPHROPATHY ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (b) (this hospital) attended the deceased from 4/5 , 19 87 , to 5/5 , 19 87 , that (b) (we) last saw the deceased alive on 5/5 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Joseph C. Moxey</i>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/5/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE MAY 5, 1987		23c. NAME OF CEMETERY OR CREMATORY CARROLL CREMATORY		23d. LOCATION CITY OR TOWN HAMPSTEAD COUNTY CARROLL STATE MD			
24. FUNERAL DIRECTOR <i>Robert A. Myers</i>				25a. DATE REC'D. BY REGISTRAR MAY 07 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 14272
REG. NO.1. FOR
STATE
REGISTRAR

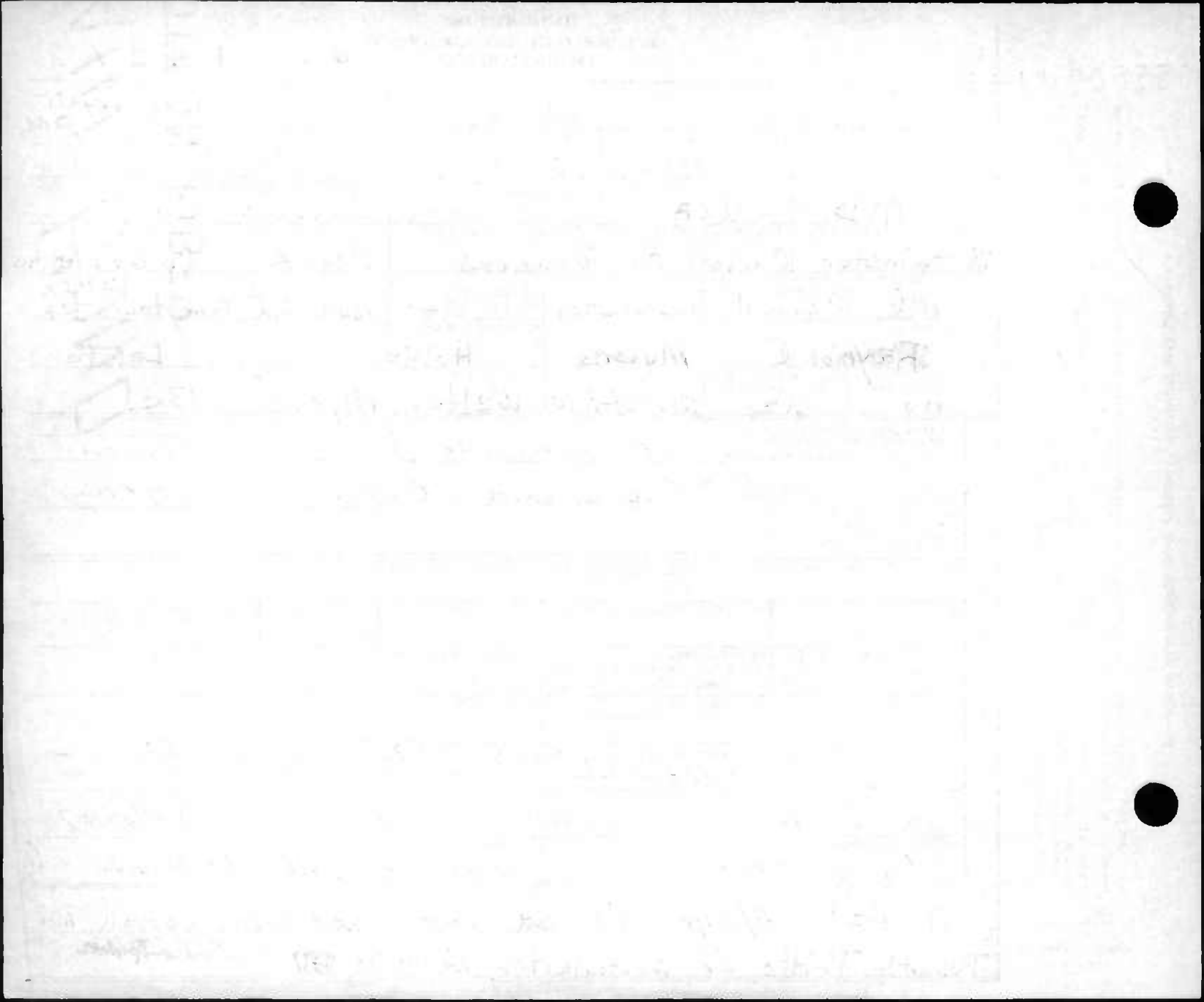
1. DECEASED NAME (TYPE OR PRINT) Azalea Myers			2a. DATE OF DEATH MONTH 5 DAY 26 YEAR 87		2b. HOUR 9:55
3. SEX F	4. RACE Can	5. DATE OF BIRTH MONTH 6 DAY 28 YEAR 14		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. MD	
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk	
13a. STATE MD		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster	
14. FATHER'S NAME Raymond		15. MOTHER'S MAIDEN NAME Hollis		16. ADDRESS Leister	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 213-019196		17. INFORMANT Walter Myers	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma Colon DUE TO, OR AS A CONSEQUENCE OF (c) gears		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH gears
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/23 , 19 87 , to 5/26 , 19 87 , that (I) (we) host saw the deceased alive on 5/26 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE John E. Steers		22c. DATE SIGNED 5/27/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John E. STEERS		22e. ADDRESS 122 Washington Hb. Westminster, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/29/87	23c. NAME OF CEMETERY OR CREMATORY Pleasant Valley	23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll Md
24. FUNERAL DIRECTOR NAME Robert K. Pritts, Sr.		25a. DATE REC'D. BY REGISTRAR 01 1987	
ADDRESS Westminster, Md		25b. REGISTRAR'S SIGNATURE John Burden-Hendall	



054402 MAY 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial or cremation.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 14273

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CLARENCE RUBEN NELSON		05/19/87		7:35 PM	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 11/09/96	6. AGE (IN YEARS LAST BIRTHDAY) 90	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) MINNESOTA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD		
10. CITY OR TOWN OF DEATH WESTMINSTER	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION CARROLL COUNTY GENERAL HOSP.		12a. USUAL OCCUPATION FARMER	12b. KIND OF BUSINESS OR DAIRY	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD STATE FREDERICK UNION BRIDGE		13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13c. STREET ADDRESS AND CITY 11330B CLEMSONVILLE RD. 21791		
14. FATHER'S NAME CHRISTOPHER NELSON		15. MOTHER'S MAIDEN NAME JULIA HANSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES		16b. SOCIAL SECURITY NO. 229-01-6702	17. INFORMANT ELLEN W. NELSON		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DEHYDRATION</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>RENAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Arthur L. Rudolph</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Arthur L. RUDOLPH MD		22e. ADDRESS 524-B BALTIMORE BLVD WESTMINSTER, MD 21157			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 05/22/87	23c. NAME OF CEMETERY OR CREMATORY EVERGREEN MEMORIAL GARD		23d. LOCATION PINKSBURG CARROLL MD STATE
24. FUNERAL DIRECTOR D. D. HARTZLER		UNION BRIDGE, MD		25. DATE REC'D BY REGISTRAR MAY 25 1987	
				25b. REGISTRAR'S SIGNATURE <i>Julia Johnson</i>	

RECEIVED
JAN 15 1972
FBI - NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7

REG. NO.

1 4 2 7 4

FOR
1- STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) KENNETH LUTHER PALMER			2a. DATE OF DEATH MONTH DAY YEAR 5 30 87			2b. HOUR 5A M	
3 SEX MALE	4 RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR MARCH 19 1911	6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) UNIONTOWN, MD.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH CARROLL CO. MD.				
10 CITY OR TOWN OF DEATH FINKSBURG	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2807 CEDARHURST RD.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MILL WORKER		12b KIND OF BUSINESS OR INDUSTRY LINOLEUM.		

13a STATE MARYLAND			13b COUNTY CARROLL		13c CITY OR TOWN FINKSBURG		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 2807 CEDARHURST RD. 21048	
14 FATHER'S NAME FIRST MIDDLE LAST FRANK PALMER			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADA WILLET						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE		17 INFORMANT ETTA PALMER		ADDRESS 2807 CEDARHURST RD. FINKSBURG, MD. 21048		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	(b) Arteriosclerosis	Years.
	(c)	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (i)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
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21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE
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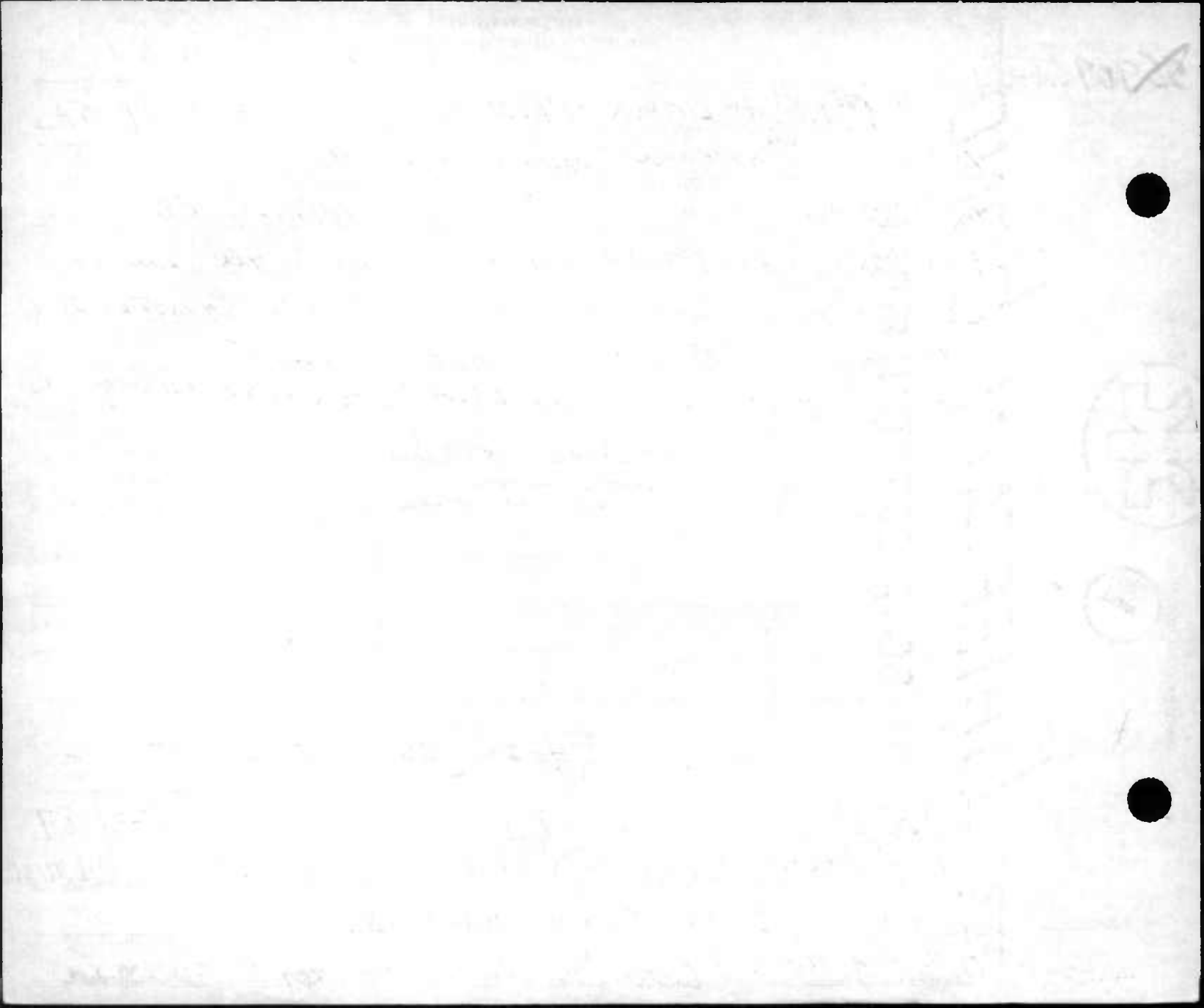
22a I certify that (I) (the hospital) attended the deceased from **5-29 87** to **5-30 87**, that (I) (we) lost
saw the deceased alive on **5-29 87**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did not) saw the body after death.

22b SIGNATURE C.E. Williams	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED 5-31-87
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22d PHYSICIAN'S NAME (IF OTHER) C.E. Williams M.D.	22e ADDRESS 11904 Rustentown Rd. Rustentown Md. 21136
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23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE JUNE 2, 1987	23c NAME OF CEMETERY OR CREMATORY EVERGREEN MEMORIAL GARDENS	23d LOCATION CITY OR TOWN COUNTY STATE
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24 FUNERAL DIRECTOR NAME Robert A. Myers	25a DATE REC'D. BY REGISTRAR JUN 03 1987	25b REGISTRAR'S SIGNATURE R.A. Fisher
---	--	---



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8714275	
1- FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		
PAUL J. PROSSER									5 31 87 4:10 AM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS (LAST BIRTHDAY))			7b. HOUR	
MALE		White		11 26 95			91			4:10 AM	
7a. BIRTHPLACE (STATE OR FOREIGN)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND			U.S.						CARROLL COUNTY MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								
WESTMINSTER			CARROLL CATHEDRAL VILLAGE								
12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY								
Executive			Chemical								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
MARYLAND			CARROLL			Westminster			YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET ADDRESS / ZIP CODE					
JOHN			Magdelene			201 Saint Marks Way 21157					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT					
Yes			WW I			Mrs. Adeline A. Prosser, same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>TERMINAL PNEUMONITIS</u>										4 DAYS	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIO-RESPIRATORY FAILURE</u>										5 DAYS	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ATHEROSCLEROTIC CARDIOVASCULAR DS.</u>										5 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			HOUR A.M. MONTH DAY YEAR								
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5/31/87</u> to <u>5/31/87</u> that (we) last saw the deceased alive on <u>5/31/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
Daniel I. Welliver			MD						5-31-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
DANIEL I. WELLIVER MD			218 W. 11th St. MED. CENTER WESTMINSTER, MD 21157								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			
Burial			06/02/1987		Holy Redeemer Cem.			Baltimore City, Maryland			
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Leonard J. Ruck, Inc. Baltimore, Maryland						JUN 1 1987			Julia Gordon-Ruck		

054483 MAY 25 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14276

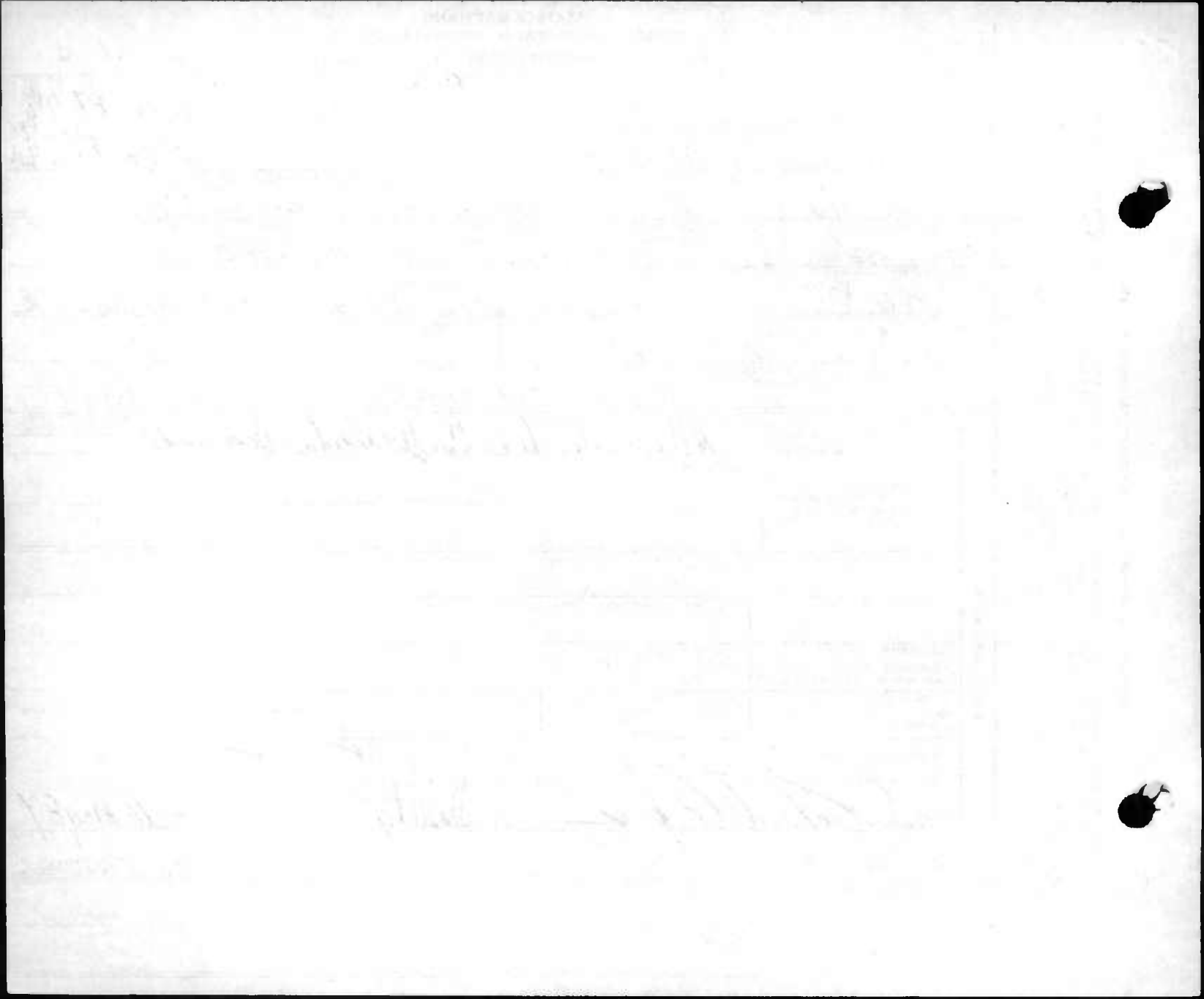
1. DECEASED NAME (TYPE OR PRINT) Aaron FRANKLIN RICE			2a. DATE KNOWN OF DEATH ESTIMATED 5/16/87 MATED 9/8/87	
3. SEX MALE	4. RACE Caucasian	5. DATE OF BIRTH MONTH 10 DAY 29 YEAR 58	6. AGE (IN YEARS) (LAST BIRTHDAY) 98 YRS.	7. IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN 0
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BETHL MD		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
11. CITY OR TOWN OF DEATH MANCHESTER		12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Long View Nsg. H. 3332 MAIN ST		13. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) CHARTER
14. STATE MD		15. COUNTY FREDERICK		16. CITY OR TOWN THURMONT
17. FATHER'S NAME FIRST JOSEPH MIDDLE A LAST RICE		18. MOTHER'S MAIDEN NAME FIRST FRANCES MIDDLE ELIZABETH LAST MOSER		19. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		21. SOCIAL SECURITY NO. 218-24-1744		22. INFORMANT ADDRESS ERMA Black Mt View Pt Thurmont
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE Richard A. Jones		TITLE (SPECIFY) Deputy		DATE SIGNED 16 May 87
EXAMINER'S NAME (TYPE OR PRINT) Richard A. Jones		ADDRESS Carroll Cr. GEN. Hosp. Westminster		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/19/87		23c. NAME OF CEMETERY OR CREMATORY WELLER CEMETERY
24. FUNERAL DIRECTOR NAME ROBERT E. DAILEY & SON, P.A.		ADDRESS 615 E. MAIN ST.		25a. DATE REC'D. BY REGISTRAR MAY 25 1987
				25b. REGISTRAR'S SIGNATURE John Jackson

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEMANDS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE GENERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 14277

REG. NO.

FOR
1. STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EAIL W. Ruby			2a. DATE OF DEATH MONTH DAY YEAR 5/12/87		2b. HOUR 4:37pm
3. SEX male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 10/19/19		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. MD.	
10. CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Carroll	13c. CITY OR TOWN Hampstead	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 4826 Black Rock Road 21074		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertie M. Still			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 213-16-0802		17. INFORMANT ADDRESS Mrs. Viola Ruby, Hampstead, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH instant
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>5-15-87</u> , to <u>5-12-87</u> , that (I) (we) lost saw the deceased alive on <u>5-6-87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>Chitrachedu Nagananna</u>		DEGREE MD		22c. DATE SIGNED 5/12/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHITRACHEDU NAGANNA		22e. ADDRESS 700 A poole Rd Westminster MD 21157			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5-15-87	23c. NAME OF CEMETERY OR CREMATORY Grace Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Upperco Balto Md.	
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md.		ADDRESS		25a. DATE BY REGISTRAR MAY 14 1987	25b. REGISTRAR'S SIGNATURE Julia Linder-Rudolph

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as occurring, show any injury, or other traumatic event, the medical history, and the circumstances.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 14278

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST CHARLES EDWARD SELBY		2a. DATE OF DEATH MONTH DAY YEAR 05/27/87		2b. HOUR 1054 M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12/10/18		6. AGE (IN YEARS (LAST BIRTHDAY)) 68	
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.	
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION CARROLL COUNTY GENERAL HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY ROADS DEPT.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD		13b. CITY OR TOWN CARROLL		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS, ZIP CODE 209 SHAEFFER AVE. 21157	
14. FATHER'S NAME FIRST MIDDLE LAST PHILIP EDWARD SELBY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE STITELY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF NONE, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 220-16-1512		17. INFORMANT THOMAS J. SELBY		ADDRESS 289 W. MAIN ST. WESTMINSTER, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>symptomatic coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>arteriosclerosis</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6/24</u> 19 <u>83</u> , to <u>5/29</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/26</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Park N. Espenschade</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/27/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Park N. Espenschade		22e. ADDRESS 419 Malcolm Dr. Westminster, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 05/30/87		23c. NAME OF CEMETERY OR CREMATORY LOCUST GROVE CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE NR. MT. AIRY FRED. MD	
24. FUNERAL DIRECTOR NAME D. HARTZLER		NEW WINDSOR, MD		25a. DATE REC'D. BY REGISTRAR JUN 1 1987		25b. REGISTRAR'S SIGNATURE <u>Park N. Espenschade</u>	

Area 1 S 100 200

Area 2 S 100 200

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 14279
REG. NO.

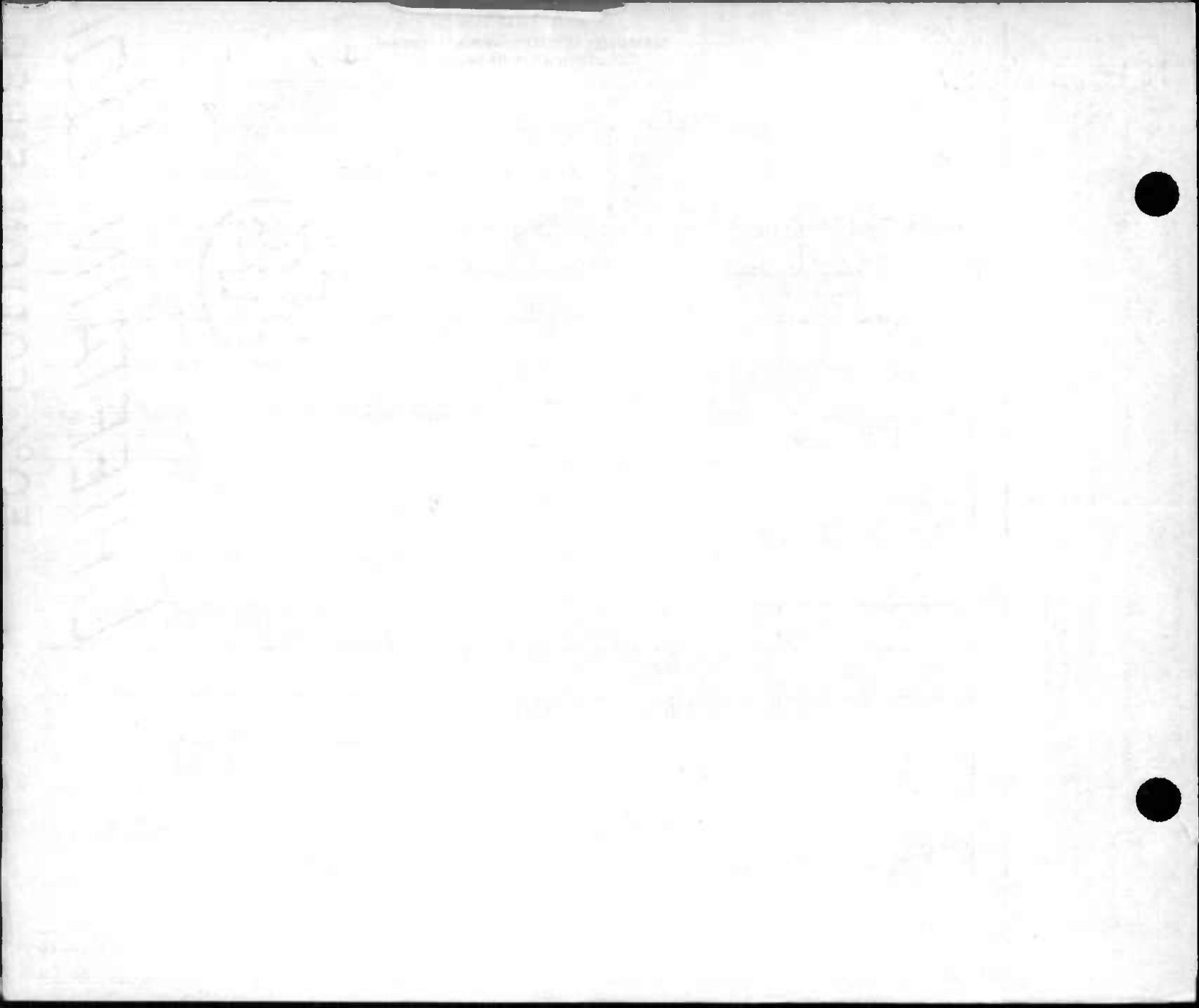
FOR 1. STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <i>Clarence</i>		FIRST <i>VICTOR</i> MIDDLE <i>Senft</i> LAST <i>1</i>		2a. DATE OF DEATH MONTH <i>5</i> DAY <i>7</i> YEAR <i>87</i>		7b. HOUR <i>8¹⁵ P.M.</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH <i>11</i> DAY <i>20</i> YEAR <i>03</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>83</i> YRS		7a. UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>USA-Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll</i> MD			
10. CITY OR TOWN OF DEATH <i>Sykesville Md.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Sykesville Elder Care Center</i>		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <i>Farmer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>AGRICULTURE</i>			
13a. STATE <i>Taneytown Md.</i>		13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Taneytown, Md.</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>3633 SENFT RD / 21787</i>	
14. FATHER'S NAME FIRST <i>Harry</i> MIDDLE <i>Senft</i> LAST <i></i>		15. MOTHER'S MAIDEN NAME FIRST <i>Maggie</i> MIDDLE <i>Hailey</i> LAST <i></i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>218-40-2665</i>		17. INFORMANT ADDRESS <i>Carelyn B. Shambaugh, R.N.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>C. 14. F</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>A.S.C.V.D</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i></i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>April 7</i> , 19 <i>87</i> , to <i>May 7</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>May 24</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Jose L. Chapula, M.D.</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>5/8/87</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jose L. Chapula, M.D.</i>			
22e. ADDRESS <i>6342 Barnet Ave. SYKESVILLE</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>05/11/88</i>		23c. NAME OF CEMETERY OR CREMATORY <i>TRINITY LUTHERAN CEM.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>TANEYTOWN, CARROLL, MARYLAND</i>			
24. FUNERAL DIRECTOR NAME <i>SKILES FUNERAL HOME</i>		ADDRESS <i>136 E. BALTIMORE ST. TANEYTOWN, MD 21787</i>		25a. DATE REC'D. BY REGISTRAR <i>MAY 18 1987</i>		25b. REGISTRAR'S SIGNATURE <i>John B. Bader</i>			

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 38 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 14280

REG. NO.

FOR
1. STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Irene M. Shaw				2a. DATE OF DEATH MONTH 5 DAY 9 YEAR 87				2b. HOUR 0425 M.	
3. SEX Female		4. RACE CAUC.		5. DATE OF BIRTH MONTH 8 DAY 23 YEAR 03		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mo		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.			
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Beutician		12b. KIND OF BUSINESS OR INDUSTRY HAIR			
13a. STATE Md.		13b. COUNTY CARROLL		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1500 Fannie Dorsey Rd. 21784	
14. FATHER'S NAME FIRST William MIDDLE Mintner LAST 				15. MOTHER'S MAIDEN NAME FIRST Letha MIDDLE Wray LAST 					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 486 38 9067		17. INFORMANT ADDRESS Robert Shaw Sykesville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) atherosclerotic heart disease									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (b) 									
DUE TO, OR AS A CONSEQUENCE OF (c) 									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Hypertension, pulmonary fibrosis, chronic obstructive lung									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS IN CERTIFYING CAUSE OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from 4/28 , 19 87 , to 5/9 , 19 87 , that I (we) last saw the deceased alive on 5/8 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE Paul Espenschade MD				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/9/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Park Espenschade				22e. ADDRESS Westminster, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 5-12-87		23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park		23d. LOCATION CITY OR TOWN COUNTY STATE St. Louis Mo.			
24. FUNERAL DIRECTOR NAME Haight Funeral Home ADDRESS Box 195 Sykesville				25a. DATE REC'D. BY REGISTRAR MAY 12 1987		25b. REGISTRAR'S SIGNATURE Lin. Friedman-Randall			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 60M 7/84
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or inhumation.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 14281	
1. DECEASED NAME (TYPE OR PRINT) ELMA L. SHOEMAKER						2a. DATE OF DEATH MONTH DAY YEAR 5 1 87		2b. HOUR 1450M			
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 4 1896		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.					
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County Gen. Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House-wife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE md		13b. COUNTY CARROLL		13c. CITY OR TOWN Taneytown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3202 Harney Rd 21787			
14. FATHER'S NAME FIRST MIDDLE LAST David - Zentz				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie - Stansbury							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-44-9301		17. INFORMANT ADDRESS Vivian Phillips / 151 W. Baltimore St. Taneytown, Md. 21787							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTIC SHOCK DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) E. Coli SEPTICEMIA DUE TO, OR AS A CONSEQUENCE OF (c) ASCENDING CHOLANGITIS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) CAD & DISEASE											
19a. DATE OF OPERATION 4-30-87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED OBSTRUCTIVE JAUNDICE				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 611 Harney Rd. Westminster							
22a. I certify that (I) (this hospital) attended the deceased from 4-26 , 19 87 , to 5-1 , 19 87 , that (I) (we) last saw the deceased alive on 5-1 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE MANUEL J. SERRA DEGREE MD						22c. DATE SIGNED MAY 07 1987					
23a. PHYSICIAN'S NAME (TYPE OR PRINT) MANUEL J. SERRA						23b. ADDRESS 611 Harney Rd. Westminster					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-4-1987		23c. NAME OF CEMETERY OR CREMATORY Weller's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Thurmont, Frederick, Md.					
24. FUNERAL DIRECTOR NAME Skiles funeral home / 136 E. Baltimore st. Taneytown, Md. 21787						25a. DATE REC'D. BY REGISTRAR MAY 07 1987		25b. REGISTRAR'S SIGNATURE Eric D. ...			

MEDICAL CERTIFICATION

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Journal of Internal Medicine 247: 391–397

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55979 JUN -

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

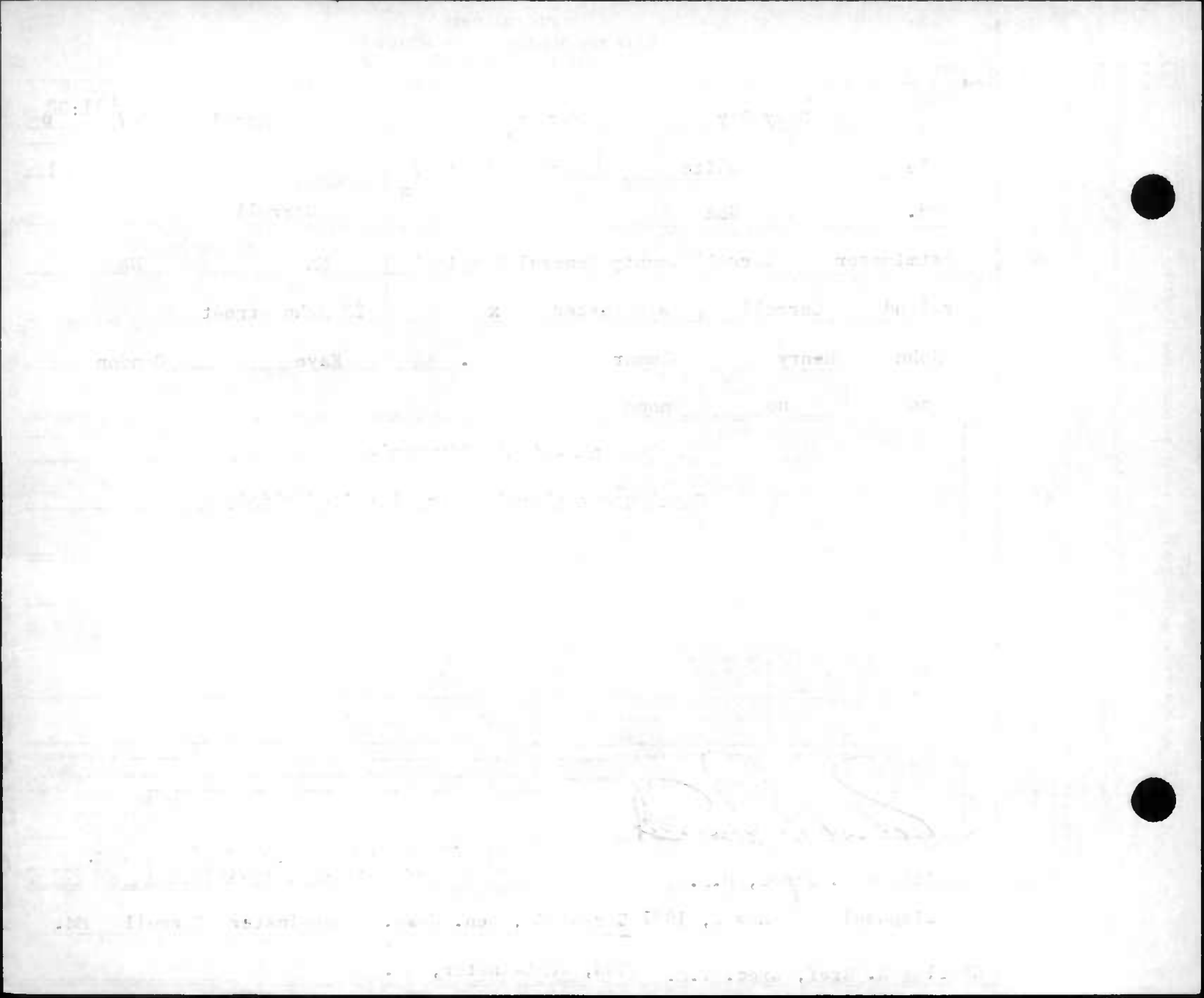
BP_____

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
<div> <div>FOR STATE REGISTRAR</div> <div>6714282</div> <div>REG. NO.</div> </div>											
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
Baby Boy Shumar				April 30 1987				11:00 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
male		white		April 30 1987		YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		USA				Carroll				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Westminster		Carroll County General Hospital				NA		NA			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland				Carroll		Westminster		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		22 John Street 21157	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
John Henry Shumar				A. Kaye Condon							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
no				no		none					
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Immature non-viable live male											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) Spontaneous abortion, undetermined etiology											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			HOUR A.M. MONTH DAY YEAR								
			P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION			CITY OR TOWN COUNTY STATE		
WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK			(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			STREET					
22. I certify that (a) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (b) (we) lost _____ the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (all) did not lose the body after death, _____)											
22a. SIGNATURE						DEGREE		22c. DATE SIGNED			
Richard A. Jones, M.D.								5/19/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
Richard A. Jones, M.D.						Carroll County General Hospital, Inc. 200 Memorial Avenue, Westminster, MD 21157					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			
disposal			May 2, 1987		Carroll Co, Gen. Hosp.			Westminster Carroll Md.			
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Charles R. Graf, Exec. v.p.						CCGH, Westminster, Md.		5-3-87			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 14283

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANK N. SIES		2a. DATE OF DEATH MONTH DAY YEAR 5 16 87		2b. HOUR 12:10 P	
3. SEX Male	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR May 8, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.	
10. CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) West. Nursing & Conv. Ctr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Master Plumber		12b. KIND OF BUSINESS OR INDUSTRY Plumbing

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster	
14. FATHER'S NAME FIRST MIDDLE LAST Noah Sies		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Hare			

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) na	17. INFORMANT 2816 Radius Road Roger Sies, Silver Spring, Md. 20902
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Atherosclerotic Heart Disease**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)
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21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
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22a. I certify that (I) (this hospital) attended the deceased from 2/16/86 to 5/16/87 , that (I) (we) last saw the deceased alive on 5/16/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
--

22b. SIGNATURE Vimala N. NAGANNA	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 5/16/87
--	---------------------	--	------------------------------------

22d. PHYSICIAN'S NAME (TYPE OR PRINT) VIMALA N. NAGANNA	22e. ADDRESS 700A Poole Rd, Westminster, MD 21157
---	---

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/19/87	23c. NAME OF CEMETERY OR CREMATORY Westminster	23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll MD.
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24. FUNERAL DIRECTOR NAME Robert Kyle Pritts Jr. Westminster, Md.	25a. DATE REC'D. BY REGISTRAR MAY 21 1987	25b. REGISTRAR'S SIGNATURE [Signature]
--	---	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8714284

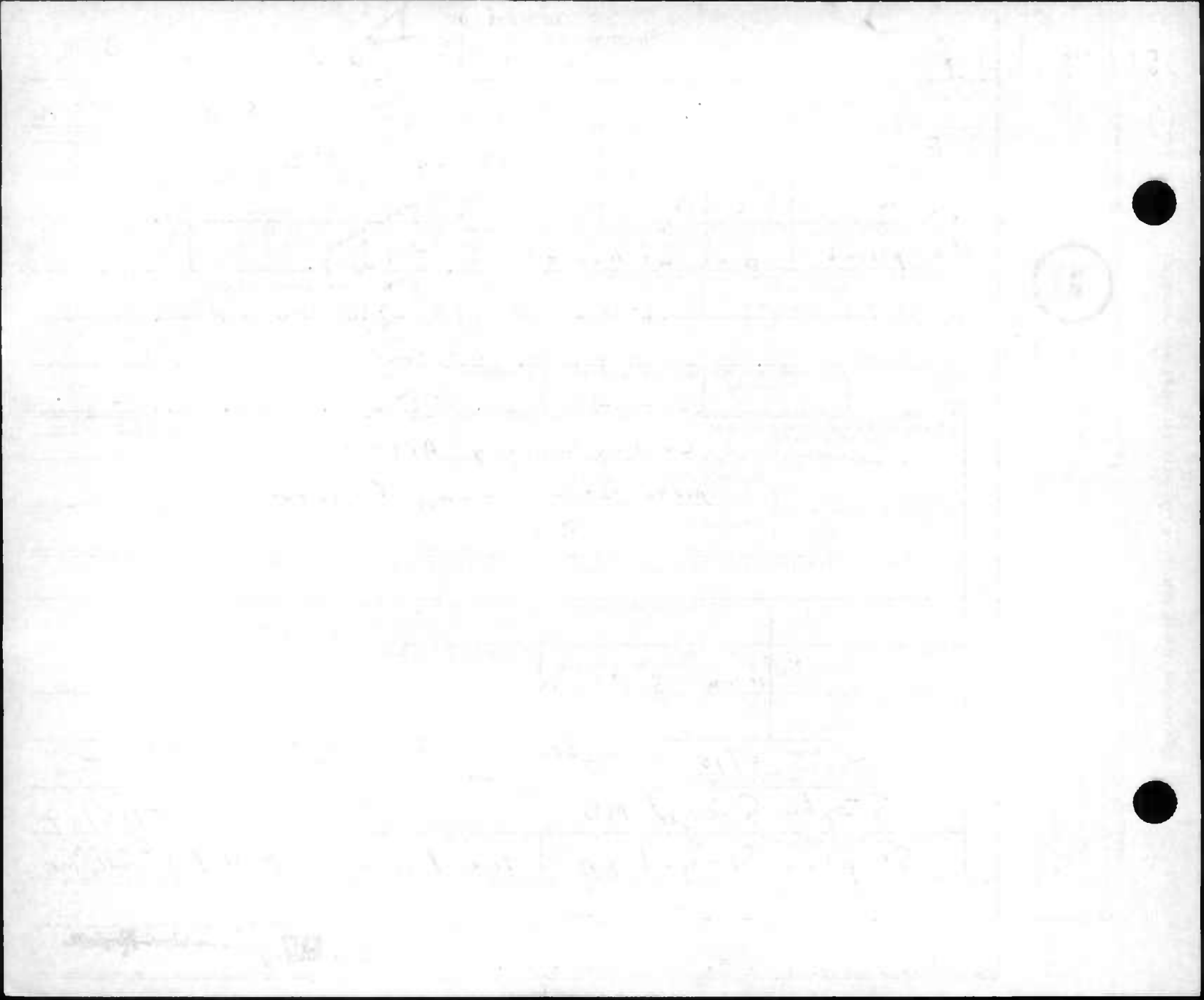
REG. NO.

FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
FIRST MIDDLE LAST				Sharon A. Small				5 22 87				12:20 AM			
3. SEX F				4. RACE W				5. DATE OF BIRTH MONTH DAY YEAR 12 30 44				6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. USA				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. MD.			
10. CITY OR TOWN OF DEATH Hampstead				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) died at home and Ct.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mgr.				12b. KIND OF BUSINESS OR INDUSTRY C&P			
13a. STATE Maryland				13b. COUNTY Carroll				13c. CITY OR TOWN Hampstead				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e. STREET ADDRESS / ZIP CODE 1221 Woodland Ct. 21074				14. FATHER'S NAME FIRST MIDDLE LAST Raymond R. Burns, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adelaide Raiber							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				16b. SOCIAL SECURITY NO. 219-42-0866				17. INFORMANT Mr. William L. Small, Jr.				ADDRESS Hampstead Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic Lung Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 12:20 AM 5 22 1987				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from 3/11, 1986, to 5/22, 1987, that (I) (we) last saw the deceased alive on 5/15, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Stephen Siegel MD				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/22/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen Siegel MD				22e. ADDRESS 70K Painters Mill Rd Owings Mills MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 5-23-87				23c. NAME OF CEMETERY OR CREMATORY Carroll Cremation				23d. LOCATION CITY OR TOWN COUNTY STATE Hampstead Carroll Md.			
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md.				ADDRESS				25a. DATE REC'D. BY REGISTRAR MAY 28 1987				25b. REGISTRAR SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.



54745 MAY 20 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 will be filed with 172 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

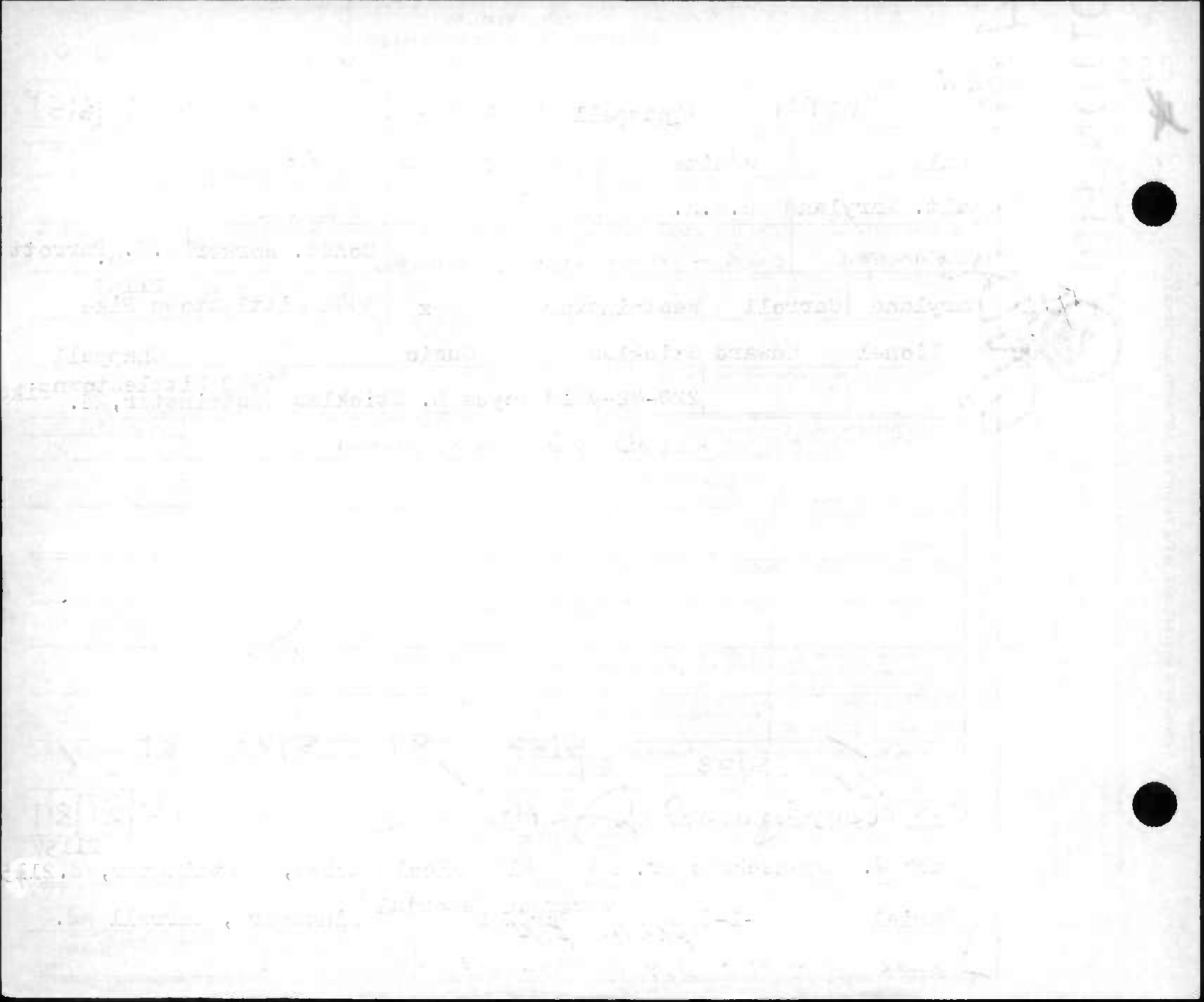
IMPORTANT: If item 21 is marked "x", item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 14285 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Irving Shelman Spencer					2a. DATE OF DEATH MONTH DAY YEAR 05 26 87					2b. HOUR 2:20 PM	
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 01 24 10			6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Patapsco, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. MD.				
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. General Hospital					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory Worker		12b. KIND OF BUSINESS OR INDUSTRY Congoleum		
13a. STATE MD		13b. COUNTY Carroll		13c. CITY OR TOWN Finksburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2112 Spencer Lane 21048			
14. FATHER'S NAME FIRST MIDDLE LAST Oliver Spencer					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Davidson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-09-7830		17. INFORMANT Naomi C. Spencer 2112 Spencer Lane Finksburg, Md. 21048							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) renal failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) gastric carcinoma DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 11a Chronic obstructive lung disease, 40% pneumonia											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) (this hospital) attended the deceased from 5/24 , 19 87 , to 5/26 , 19 87 , that (b) (we) last saw the deceased alive on 5/25 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Park W. Espenschade Jr.						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Park W. Espenschade Jr. MD						22e. ADDRESS Westminster, Md. 21157 218 Washington Heights Medical Center					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-28-87		23c. NAME OF CEMETERY OR CREMATORY Wesley Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Upperco Carroll Md.				
24. FUNERAL DIRECTOR Thomas D. Fletcher & Son F.H. 254 East Main Street Westminster, Maryland 21157						25a. DATE REC'D. BY REGISTRAR MAY 27 1987		25b. REGISTRAR'S SIGNATURE Julia Davis			

BP

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 14286
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DEAN Chappell STICKLES			2a. DATE OF DEATH MONTH DAY YEAR 5 28 87			2b. HOUR 1615 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 08 42		6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balt. Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.			
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL COUNTY GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING HOURS) Const. Worker		12b. KIND OF BUSINESS OR INDUSTRY A. Co. Parrott	
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3442 Littlestown Pike 21157	
14. FATHER'S NAME FIRST MIDDLE LAST Lionel Edward Stickles				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie Chappell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 220-42-9818		17. INFORMANT Joyce L. Stickles Westminister, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) renal cell carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (1) (this hospital) attended the deceased from 5/22 87 to 5/28 87, that (1) (we) last saw the deceased alive on 5/28 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE S. W. Espenschade				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/29/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Park W. Espenschade Jr. MD				22e. ADDRESS 410 Malcolm Drive, Westminster, Md. 21157					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-1-87		23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg, Carroll Md.			
24. FUNERAL DIRECTOR NAME James Hesketh				ADDRESS 254 E Main St		25a. DATE REC'D. BY REGISTRAR JUN 1 1987		25b. REGISTRAR'S SIGNATURE Julia Borden-Randall	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 14287
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CLARIE VICTORIA STONER			2a. DATE OF DEATH MONTH DAY YEAR May 25 87			2b. HOUR 1130 A			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 30 1891		6. AGE (IN YEARS LAST BIRTHDAY) 95		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.			
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD			13b. COUNTY CARROLL		13c. CITY OR TOWN Manchester		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST ALONZA N. YINGLING			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA RIDGE			13e. STREET ADDRESS / ZIP CODE 3816 Miller St. RD. 21102			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. E 89820		17. INFORMANT JOHN R. WENWELL ADDRESS 3817 MILLER STATION RD MANCHESTER MD 21102				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 5-18-1987 to 5-25-1987 , that (I) (we) last saw the deceased alive on 5-25-1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Christina M. Nafano MD						DEGREE MD		22c. DATE SIGNED 5/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHRISTINA M. NAFANO						22e. ADDRESS 700 A POOLE RD. WESTMINSTER MD 21157			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE MAY 25, 1987		23c. NAME OF CEMETERY OR CREMATORY LAKE VIEW MEMORIAL		23d. LOCATION CITY OR TOWN COUNTY STATE ELDERSBURG CARROLL MD		
24. FUNERAL DIRECTOR NAME R. J. Hightower			24b. DATE RECEIVED BY REGISTRAR MAY 28 1987		24c. REGISTRAR'S SIGNATURE John R. Wenwell				

MEDICAL CERTIFICATION

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MAY 18 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7

REG. NO.

1 4 2 8 8

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WOODROW WILSON UTZ			2a. DATE OF DEATH MONTH DAY YEAR May 14, 1987		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR November 22, 1914		6. AGE (IN YEARS, EAST BIRTHDAY) 72 YRS. # UNDER 1 YEAR: MONTHS DAYS # UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County, MD.	
10. CITY OR TOWN OF DEATH Taneytown,	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12 Wilson Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Building-Mover	12b. KIND OF BUSINESS OR INDUSTRY Labor	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Carroll	13c. CITY OR TOWN Taneytown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Solas K. - Utz			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida - Etchison		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 160-14-3242		17. INFORMANT ADDRESS 12 Wilson Ave. Catherine H. Utz / Taneytown, Md. 21787	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the pancreas</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-5-87
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a. DATE OF OPERATION 3-87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Cx of pancreas</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>2-5-87</u> , 19 <u>87</u> , to <u>5-13</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5-13</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>W. Iglesias</u>		DEGREE H.O.		22c. DATE SIGNED 5/14/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wenifredo N. Iglesias, MD		22e. ADDRESS 49 Frederick St./ Taneytown, Md. 21787			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 18, 87	23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg, Carroll, Maryland
24. FUNERAL DIRECTOR NAME Skiles Funeral Home / Taneytown, Md. 21787		25a. DATE REC'D. BY REGISTRAR MAY 18 1987		25b. REGISTRAR'S SIGNATURE Julia Dandrea-Rodriguez	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card from permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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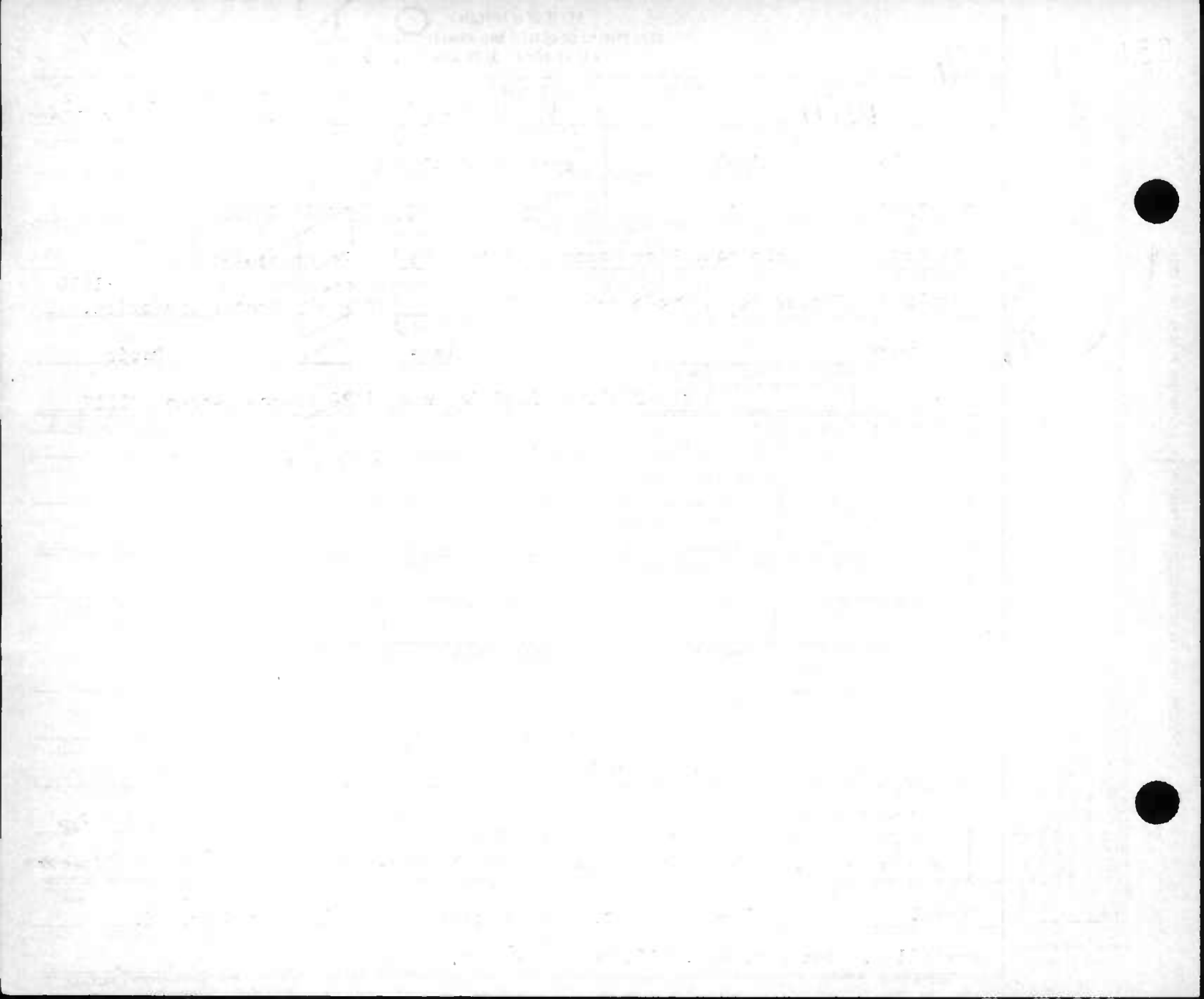
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) WILMA MAE WILKINS		2a. DATE OF DEATH May 3 20 87		2b. HOUR 1:50 AM		REG. NO. 14289			
3 SEX Female	4 RACE Black	5. DATE OF BIRTH MONTH DAY YEAR March 27, 1941		6. AGE (IN YEARS LAST BIRTHDAY) 46	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS.		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	10. CITIZEN OF WHAT COUNTRY? USA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant View Manor Nursing Home		12. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.			13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeping		
14. CITY OR TOWN OF DEATH Mt. Airy	15. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant View Manor Nursing Home	16. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeping		17. KIND OF BUSINESS OR INDUSTRY			18. BALTIMORE CITY OR COUNTY OF DEATH		
19. STATE Maryland	20. COUNTY Frederick	21. CITY OR TOWN Frederick	22. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	23. STREET ADDRESS / ZIP CODE Patrick Street, Frederick, Md 21710			24. FATHER'S NAME FIRST MIDDLE LAST Unknown		
25. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isolene Davis		26. SOCIAL SECURITY NO. 216-36-6299		27. INFORMANT Lucinda Brown			28. ADDRESS 1528 McKean Avenue 21217		
29. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		30. SOCIAL SECURITY NO. 216-36-6299		31. INFORMANT Lucinda Brown			32. ADDRESS 1528 McKean Avenue 21217		
33. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TERMINAL Left Breast Cancer</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Rehabilitate</u> DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
34. DATE OF OPERATION		35. CONDITION FOR WHICH OPERATION WAS PERFORMED		36. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		37. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
38. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		39. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		40. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
41. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		42. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		43. LOCATION STREET CITY OR TOWN COUNTY STATE		44. DATE SIGNED 5/28/87			
45. I certify that (I) (this hospital) attended the deceased from 10:31 1986, to 5:28 1987, that (I) (we) last saw the deceased alive on 5-14-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
46. SIGNATURE Arthur G. Jones, Jr.		47. DEGREE M.D.		48. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		49. DATE SIGNED 5/28/87			
50. PHYSICIAN'S NAME (TYPE OR PRINT) Arthur G. Jones, Jr.		51. ADDRESS 11801 Fingertown Rd. Federal Hill		52. DATE SIGNED 5/28/87					
53. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		54. DATE 5-23-87		55. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		56. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Md.			
57. FUNERAL DIRECTOR NAME Marshall W. Jones, Jr.		58. ADDRESS F.H. 4101 Edmondson Ave.		59. DATE REC'D. BY REGISTRAR MAY 28 1987		60. REGISTRAR'S SIGNATURE Julia F. Jones, Jr.			



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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 14290

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Geneva G. Yelton</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>5 6 87</u>		2b. HOUR <u>0200 AM</u>
3. SEX <u>Female</u>	4. RACE <u>White</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>7 14 1905</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>81</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>North Carolina</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <u>Carroll</u> MD		10. CITY OR TOWN OF DEATH <u>Westminster</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Carroll County General Hospital</u>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Carroll</u>	13c. CITY OR TOWN <u>Millers</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <u>4016 Schalk Rd. #2 21107</u>
14. FATHER'S NAME FIRST MIDDLE LAST <u>Ezekiel Garland</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Cenis Phillips</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>220-18-0297</u>		17. INFORMANT <u>James F. Yelton</u> <u>4016 Schalk Rd. #2</u> <u>Millers, Md. 21107</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>UREMIA</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4-27-87</u> to <u>5-6-87</u> , that (I) (we) last saw the deceased alive on <u>5-5-87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>Chitrachedu Naganawa MD</u>				22c. DATE SIGNED <u>5/6/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CHITRACHEDU NAGANAWA</u>				22e. ADDRESS <u>700 A Poole Rd. Westminster MD 21157</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>May 9, 1987</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Mem. Gardens</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Finksburg Carroll Md.</u>
24. FUNERAL DIRECTOR NAME <u>Eckhardt Funeral Chapel</u>		24b. ADDRESS <u>Manchester, Md. 21102</u>		24c. DATE REC'D. BY REGISTRAR <u>MAY 8 1987</u>	
				24d. REGISTRAR'S SIGNATURE <u>Julia Denson-Rodgers</u>	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

WYOMING

SECTION 16

TOWNSHIP 10 N

RANGE 10 E

SECTION 16

SECTION 16

SECTION 16

SECTION 16

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